

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|---------------------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 5 2 8 2 CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| MARIE E. O'BRIEN | | | | | 9 30 82 425 P M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Female | | White | | 6 19 02 | | 80 YRS | | 425 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Pennsylvania | | U.S.A. | | | | BALTIMORE, CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Catonsville | | HOUSE - IN THE PINES CATONSVILLE | | | | Housewife | | --- | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Baltimore | | Arbutus | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 915 Circle Drive 21227 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Newton | | | | Annie Malone | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | 213-05-9943 | | Elizabeth A. Yox 915 Circle Drive 21227 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | |
| 4292 Cardiac arrest | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Advanced Arteriosclerotic CVD | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/16 19 79 to 9/30 19 82, that (I) (we) last saw the deceased alive on 9/30 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.) | | | | | | | | | |
| 22a. SIGNATURE | | | | | | | | 22c. DATE SIGNED | |
| Herbert J. Leuckas, M.D. | | | | | | | | 10/1/82 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e. ADDRESS | |
| HERBERT J. LEUCKAS, M.D. | | | | | | | | 5404 EAST DR. BALTO, MD 21227 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 10/4/82 | | Moreland Memorial Pk. | | Hillendale Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS 21229 | | | | OCT 4 - 1982 | | John J. Canine | | | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | | | | |

BP

358

AM

February 23

1979

10:30

10% COLLECTED
1/11/79



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 2 8 3

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>William B. O'Brien</u> | | | 2a. DATE OF DEATH MONTH <u>10</u> DAY <u>4</u> YEAR <u>1982</u> | | | 2b. HOUR <u>10²⁹</u> PM | | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>Caucasian</u> | | 5. DATE OF BIRTH MONTH <u>7</u> DAY <u>13</u> YEAR <u>1904</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS. | | IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u> | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County, MD.</u> | | | |
| 10. CITY OR TOWN OF DEATH <u>Towson</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>St. Joseph's Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired Cab Driver</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>City of Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>502 Castle Dr., Apt. B</u> | |
| 14. FATHER'S NAME FIRST <u>William</u> MIDDLE <u>James</u> LAST <u>O'Brien</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Josephine</u> MIDDLE <u> </u> LAST <u>VOGT</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | | | 16b. SOCIAL SECURITY NO. <u>216-07-5612</u> | | 17. INFORMANT ADDRESS <u>21221</u> <u>Mr. Wm. J. O'Brien 207 Southeastern Terr.</u> | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1539

IMMEDIATE CAUSE (a)

Cardiac-Respiratory Failure

15 minutes

DUE TO, OR AS A CONSEQUENCE OF

(b)

Metastatic Carcinoma

DUE TO, OR AS A CONSEQUENCE OF

(c)

Carcinoma of Colon

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION <u>9/4/82 and 9/20/82</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intestinal Obstruction</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCOUNT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u> </u> <u> </u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <u> </u> (this hospital) attended the deceased from <u>9/4/82</u> , to <u>10/4/82</u> , that (I) (we) <u> </u> saw the deceased alive on <u>10/4/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) <u> </u> (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Donald E. Golladay, M.D.</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>10/4/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Donald E. Golladay, M.D.</u> | | | | 22e. ADDRESS <u>3701 Dupont Avenue Kensington, Maryland 20895</u> | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>10-8-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Overlea Baltimore Md</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Mitchell-Wiedefeld Home</u> | | | | ADDRESS <u>6500 York Rd 21212</u> | | 25a. DATE REC'D. BY REGISTRAR <u>OCT 11 1982</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>John A. Baird</u> | | | |

THIS DOCUMENT CONTAINS
UNCLASSIFIED INFORMATION

10/1/2014
Mr. William B. O'Brien
Commissioner
U.S.A.
St. Louis, Mo.
Missouri
St. Louis, Mo.
Missouri

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 2 8 4 REG. NO. | | | | | |
|--|--|--|---|--|--|---|--|---|--|---|--|---|---|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) EDWARD W. OGLE | | | | | | | | | | October 25, 1982 | | | | 6:20a M | |
| 3. SEX Male | | | 4. RACE Cauc. | | | 5. DATE OF BIRTH MONTH DAY YEAR 09 26 1919 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Layer | | | 12b. KIND OF BUSINESS OR INDUSTRY Local #1-Md. | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 750 Aldsworth Rd. 21222 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John ? Ogle | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie E. Myers | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) II | | | | | 16b. SOCIAL SECURITY NO. 217-03-0126 | | | 17. INFORMANT ADDRESS Mrs. Marie E. Ogle - 750 Aldsworth Road #21222 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Sepsis & Severe Dehydration 1919 DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Astrocytoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from October 18 , 19 82 , to October 25 , 19 82 , that (we) lost saw the deceased alive on October 25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE D. WADHWA | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 10/25/82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. WADHWA | | | | | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Walter Dabrowski - 1005 Dundalk Ave. #21224 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 26 1982 | | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | |

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 2 | 5 | 2 | 8 | 5 |
|--|--|--|--|--|--|--|--|---|--|--|---|----------------------------------|---|---------------------------|---|---|
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Nellie M. Oldenburg | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10. 24. 82 | | | | 2b. HOUR 4:27 P.M. | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 3 11 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. Co. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Balt. City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6600 Ridge Rd. Balto. 21237 | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James P. McDonald | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Harron | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-74-7018 | | 17. INFORMANT ADDRESS Stella Maris Hospice Md. 21204 | | 17. ADDRESS Dulaney Valley Rd. Towson | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF c) CHF, Colostomy, chronic bronchitis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 1979 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Colostomy | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Eddie Nakhuda, M.D. | | | | | | | | | | DEGREE | | 22c. DATE SIGNED 10-24-82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eddie Nakhuda, M.D. | | | | | | | | | | 22e. ADDRESS Stella Maris Hospice | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial | | 23b. DATE 10-26-82 | | 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 26 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carney | | | | | | | | |

DMED MATH

100% COTTON

Blank lined paper with two punch holes on the right side.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 5 2 8 6

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|---------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST David | | MIDDLE C. | | LAST O'Neill JR. | | 2a. DATE KNOWN OF DEATH ESTI- MATED | | MONTH 10 | | DAY 19 | | YEAR 1982 | | 2b. HOUR 12 ³⁰ PM | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH May | | DAY 11 | | YEAR 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | | IF UNDER 1 YR. MONTHS | | IF UNDER 24 HRS. HOURS | | 7c. DATE PRONOUNCED DEAD | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH PARKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARMCO STEEL | | | | 12b. KIND OF BUSINESS OR INDUSTRY STEEL WORKER | | | | | | | |
| 13a. STATE MO. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN PARKVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2517 LANTERBURY ROAD | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST David | | | | | | MIDDLE C. | | | | | | LAST O'NEILL SR. | | | | | | | |
| 15. MOTHER'S MAIDEN NAME FIRST Mary | | | | | | MIDDLE WHITT | | | | | | LAST WHITT | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 4250 → | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT FAMILY RECORDS | | ADDRESS | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET | | | | CITY OR TOWN | | | | COUNTY | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE R. Breitenecker | | | | TITLE (SPECIFY) M.D. Dep. | | | | MEDICAL EXAMINER | | | | DATE SIGNED 10/19/82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) R. BREITENECKER MD | | | | ADDRESS 68 MC | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10-22-1982 | | | | 23c. NAME OF CEMETERY OR CREMATORY Marshall and Men. Pk. | | | | 23d. LOCATION CITY OR TOWN PARKVILLE BALTO. MO. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Evans | | | | ADDRESS CH Bagatki | | | | 25a. DATE REC'D. BY REGISTRAR OCT 20 1982 | | | | 25b. REGISTRAR'S SIGNATURE John J. Gault | | | | | | | |

EVANS FUNERAL CHAPEL 8300 HARBARD ROAD

100% COTTON FIBER

MAKIN THEM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 2 8 7

REG. NO.

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Amelia L. Orla | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 13 82 | | 2b. HOUR M M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 3 22 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Dundalk | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 118 Kinship Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales | | 12b. KIND OF BUSINESS OR INDUSTRY Hess Shoe |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Emil Morisi | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Brunetti | | 13e. STREET ADDRESS 118 Kinship Road 21222 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-01-4309 | | 17. INFORMANT ADDRESS Joseph Morisi 118 Kinship Road Balto., MD. 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 4100 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1954 , 19 82 , to June 29 , 19 82 , that (I) lost saw the deceased on 6/29 , 19 82 , and that in (my) (cor) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE Lester Hebo MD | | 22c. DATE SIGNED 10/14/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LESTER HEBO | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | 25a. DATE REC'D. BY REGISTRAR OCT 18 1982 | |
| 7922 Wise Avenue Dundalk, MD. 21222 | | 25b. REGISTRAR'S SIGNATURE John J. Curren | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8 2 2 5 2 8 8

1- FOR
STATE
REGISTRAR

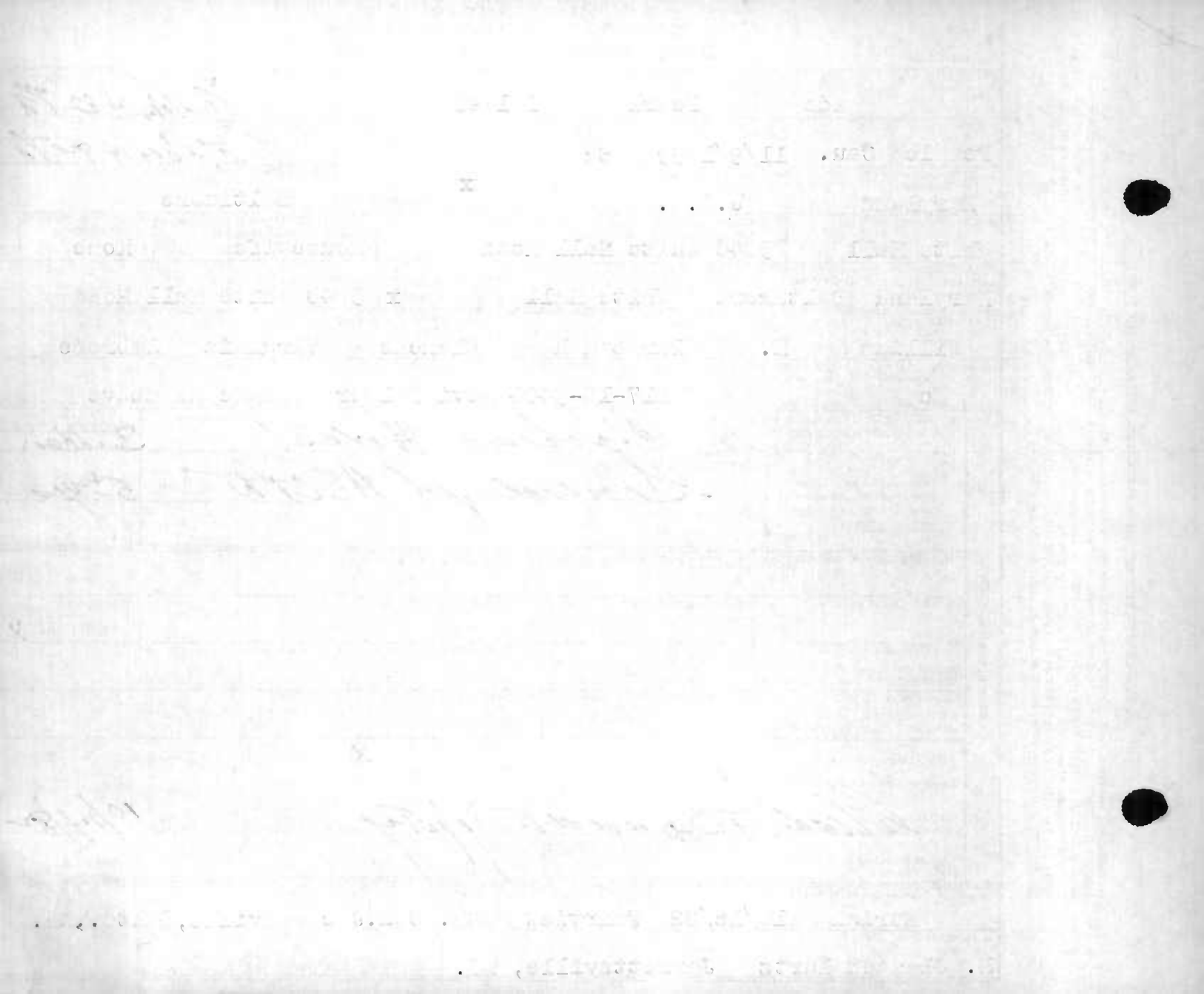
REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) COLEMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-6-82 | | | 2b. HOUR 12 PM | | | |
| 3 SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 6-9-92 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) INGENOOK NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICEMAN | | 12b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY | |
| 13a. STATE MARYLAND | | 13b. COUNTY --- | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2533 ASHTON STREET, 21223 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES O'TOOLE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET CONROY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. 220-44-5946 | | 17. INFORMANT ADDRESS MARGARET WARD 2527 ASHTON STREET, 21223 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Multiple Decubitus ulcers; Contractures of Lbs.; Parkinsonism | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-5-1982 to 10-6-1982 , that (I) (we) lost saw the deceased alive on 9-17-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE D. Saluja DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10-7-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DARSHAN S. SALUJA MD | | | | | | 22e. ADDRESS 1600 MT Royal Ave Baltimore MD 21217 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 10-09-82 | | 23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 8 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 2 5 2 8 9 | | |
|--|-----------------|--|--|---|---|--|--|--|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada Pearl Palmer | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR October 14 1982 | | |
| 3. SEX Female | 4. RACE Cau. | 5. DATE OF BIRTH MONTH DAY YEAR 11/9/1899 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 82 | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | 7. DATE PRONOUNCED DEAD MONTH DAY YEAR October 14 1982 | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore | | 10. CITY OR TOWN OF DEATH White Hall | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3040 White Hall Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN White Hall | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3040 White Hall Road | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William H. Turnbaugh | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Virginia Ambrose | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 217-12-9404 | | 17. INFORMANT Levi Palmer | | ADDRESS same as above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Sudden (c) Generalized ASCVD DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 5+ yrs | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles F. Donaldson M.D. | | | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER | | DATE SIGNED 10/14/82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Charles F. Donaldson | | | | ADDRESS Jarrettsville, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY Fairview Meth. Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Jacksonville, Balto., Md. | | |
| 24. FUNERAL DIRECTOR NAME M. Gladden Kurtz | | | | ADDRESS Jarrettsville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 21 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 2 9 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Richard Steele PAYNE SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 10/23/82 | | | 2b. HOUR 12:22 AM | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 9/1/12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH ROSSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SR | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | |
| 13a. STATE MD | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN ESSEX | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RICHARD A. PAYNE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE STONE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NAIK | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 237-07-3251 | | 17. INFORMANT ADDRESS MIRIAM PAYNE A BOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD & COPD | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Hx recurrent pulmonary emboli | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this physician) attended the deceased from Aug 19 75 to Oct 19 82, that (I) (X) last saw the deceased alive on Oct 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE Pablo E. Dibos | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PABLO E. DIBOS, M.D. | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD | |
| 24. FUNERAL DIRECTOR NAME Connelly Funeral Home | | ADDRESS 300 Maple Ave | | 25a. DATE REC'D. BY REGISTRAR OCT 27 1982 | | 25b. REGISTRAR'S SIGNATURE J. J. Connelley | |

MEDICAL CERTIFICATION

10
67
35
30
1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

8/2/01

11/1/01

11/1/01

RECEIVED
COUNTY CLERK'S OFFICE
1000 N. 1st St. - Reno, NV 89501
11/1/01



Items #18a-22a Film G575 1/3/83 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 5 2 9 1

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|--|--|---|--|--------------------------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2b. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| CONSTANCE R. PERKINS | | | | | | | | XX | | 10-16-82 | | | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Female | White | Oct 12 1935 | | 47 YRS. | | | | | | 10-16-82 | | | | | | 2:10P | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7d. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Pennsylvania | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore County | | | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Dundalk | | 1941 Stanhope Rd. | | Waitress | | Restaurant | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Baltimore | | Dundalk | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1941 Stanhope Road | | | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | | | |
| Roy | | | | Robb | | Marie | | | | Cook | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 219-32-1614 | | Victoria L. Kern | | 1941 Stanhope Road | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 7999 | | Undetermined | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | Assistant | | 10-17-82 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | 111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| Cremation | | Oct. 20, 1982 | | Green Mount | | Baltimore | | Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Leonard J. Ruck, Inc. | | Baltimore, Maryland | | OCT 20 1982 | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

0000 BP 317

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

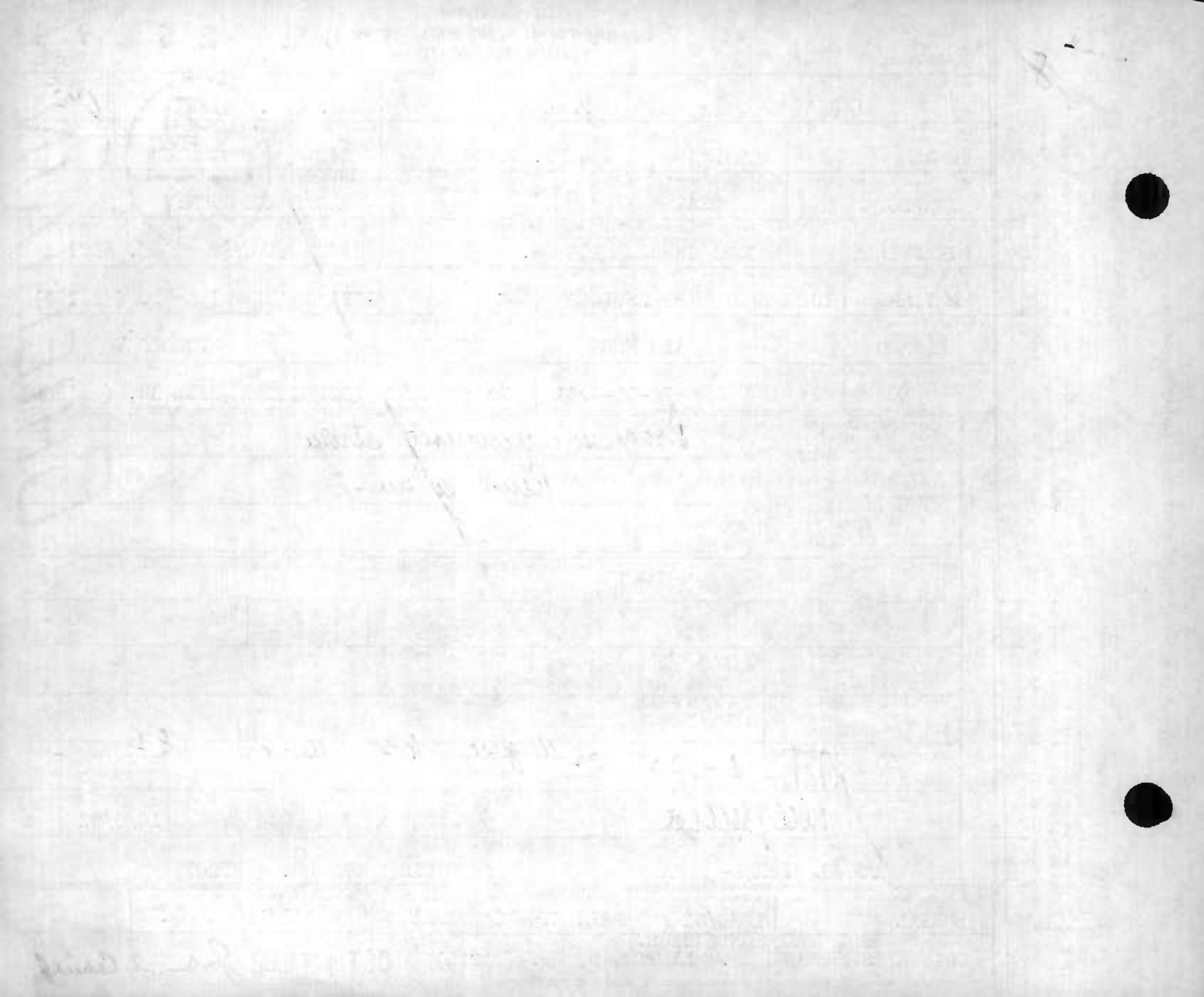
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

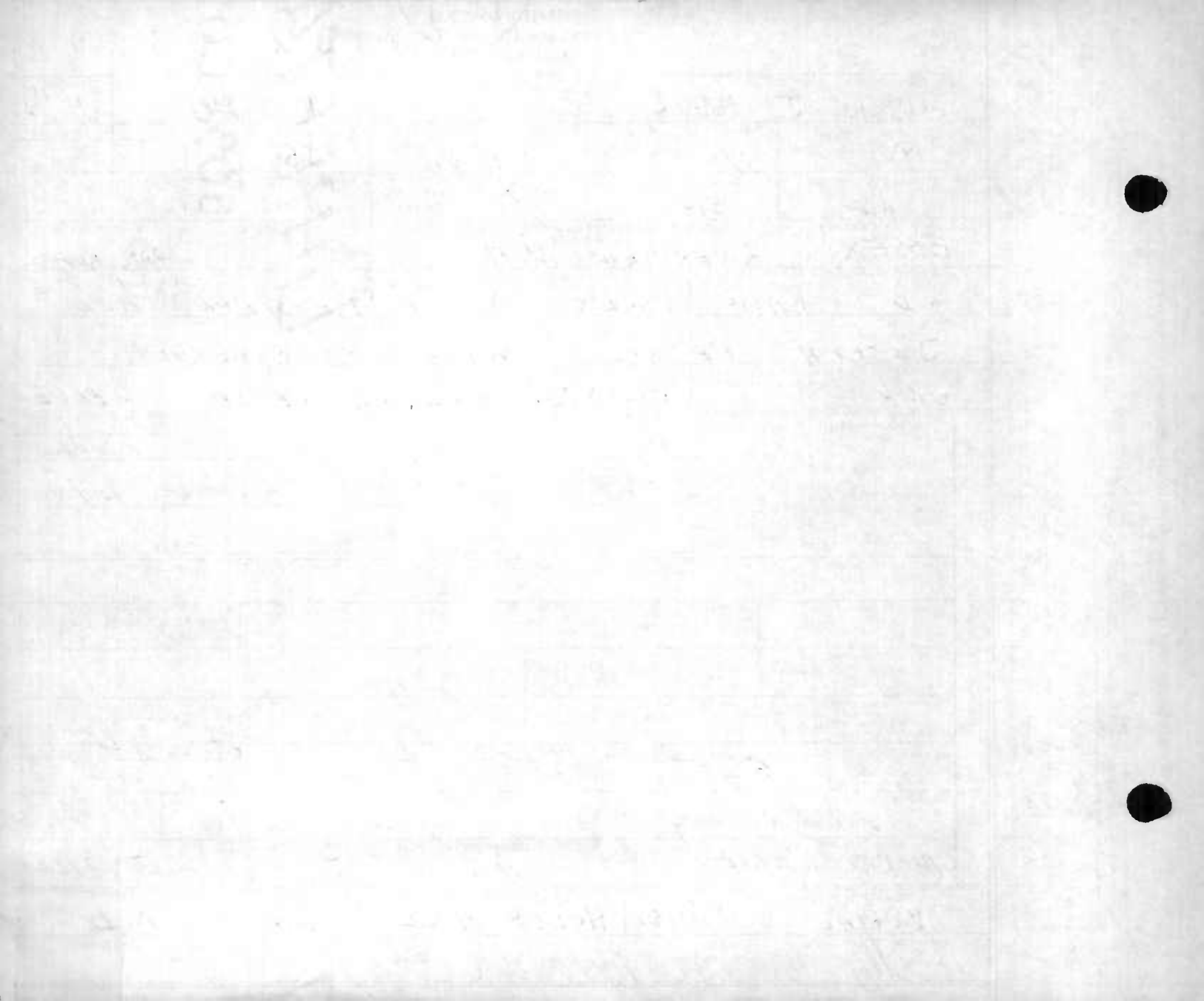
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 2 9 2
REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LAURA | | | 2a. DATE OF DEATH MONTH DAY YEAR WED. OCT. 6, 1982 | | | 2b. HOUR 6:42 A.M. | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR SEPT. 2, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH PIKESVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1321 CHURCH HILL DR. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUDGET ANALYST | | 12b. KIND OF BUSINESS OR INDUSTRY SOC. SEC. ADMN | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN PIKESVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1321 CHURCH HILL DR. (21208) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDWARD | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER TOBOLSKY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 474-01-4931 | | 17. INFORMANT ADDRESS MAX PERLMAN 1321 CHURCH HILL DR. (21208) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5860 DUE TO, OR AS A CONSEQUENCE OF Progressive recurrent stroke (b) Renal failure - DUE TO, OR AS A CONSEQUENCE OF (c) 5860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (we) (hospital) attended the deceased from 8-20-82 to 10-6-82 , that (I) (we) lost saw the deceased die on 10-6-82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (hospital) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Rafael Perez-Mera | | | | 22c. DATE SIGNED 10/6/82 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAFAEL PEREZ- MERA | |
| 22e. ADDRESS 5400 OLD COURT RD. (21207) | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | 25a. DATE REC'D. BY REGISTRAR OCT 13 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Casper | | | |



MEDICAL CERTIFICATION

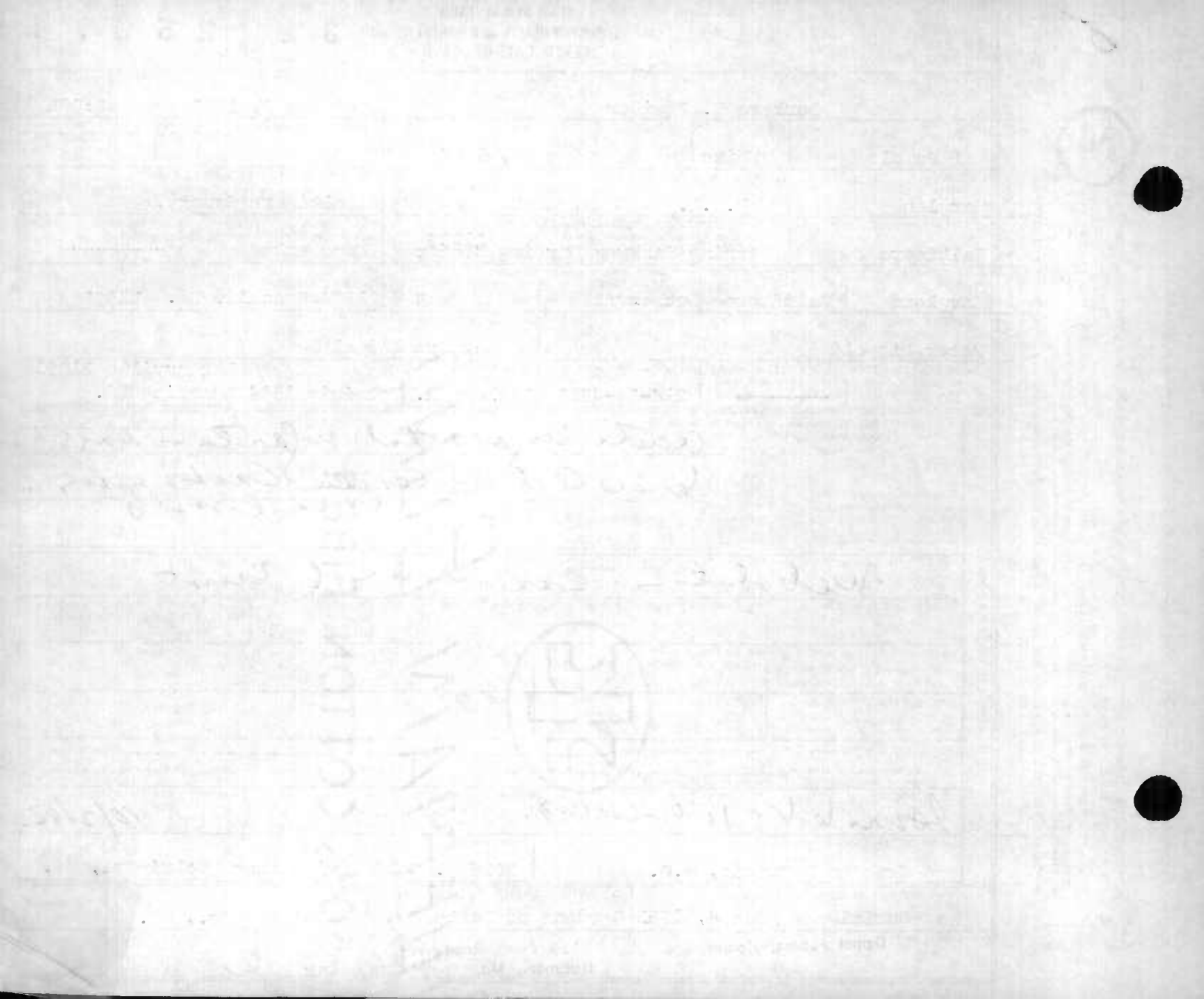


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 2 9 4 | |
|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Barbara C. Pfeifer | | October 1, 1982 | | 2:00A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | Aug 14, 1896 | 86 YRS. | MONTHS | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | Baltimore County, MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | Perring Parkway Nursing Center 21234 | | Home maker | | ----- |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Baltimore | Lutherville | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1504 Ameshire Rd. 21093 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| Peter Diepold | | | Barbara Flierl | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| No | | 214-54-4363 | Lutherville 21093 Barbara H. Patricio 1504 Ameshire Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Severe Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Metastatic carcinoma of Breast. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Gracito Patricio, M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 10/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Gracito Patricio, M.D. | | 2926 E. Cold Spring Lane Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | Oct 4, 1982 | Gardens of Faith Cem | Baltimore Co., Md. | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Dippel Funeral Homes, Inc. | | OCT 4 1982 | | John J. Conick | |
| ADDRESS | | 7110 Belair Road Baltimore, Md. | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 5 2 9 5 REG. NO. | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE P. PHILDUS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 31 82 | | 2b. HOUR 12:15 M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 5 99 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Balto. Med. Ctr. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Switchman | | 12b. KIND OF BUSINESS OR INDUSTRY Telephone | |
| 13a. STATE Md. | | 13b. COUNTY Monkton | | 13c. CITY OR TOWN Monkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Hunt Phildius | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Nash | | 13e. STREET ADDRESS 819 Corbett Road Monkton, Md. 21111 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI & II | | 17. INFORMANT Ada Beyrodt | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: C.O.P.D. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE W. J. Ellen | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. J. Ellen | | 22e. ADDRESS Randallstown, Md. 21133 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 11/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | 25a. DATE RECEIVED BY REGISTRAR NOV 8 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | |



Georg-August-Str. 108a VON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 2 9 6

REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) MILTON PIERCE | | 2a. DATE OF DEATH MONTH DAY YEAR 10-5-82 | | 2b. HOUR 8:54 | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1900 | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | IF UNDER 1 YEAR MONTHS DAYS HOURS 7 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH Randallstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) C and P Telephone Company | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Baltimore | 13c. CITY OR TOWN Balto. County | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 3520 Sussex Road |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Pierce | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Horn | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 212-05-1358 | | 17. INFORMANT Rev. Charles Frederick 9118 Bengal Road Randallstown, MD. 21133 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PULMONARY EDEMA, CHRONIC OBSTRUCTIVE Lung Disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-3 19 82 to 10-5 19 82 that (I) (we) lost saw the deceased alive on 10-5 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Orlando B. Conanan, MD. | | DEGREE | | 22c. DATE SIGNED 10-5-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. CONANAN, MD. | | 22e. ADDRESS BEGH - RANDALLSTOWN MD. 21133 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-9-82 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD. | | 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133 | | | |
| 25a. DATE REC'D. BY REGISTRAR OCT 8 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

10-22-83

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1- FOR
STATE
REGISTRAR

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|--|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ernest L. POLK | | | 2a. DATE OF DEATH MONTH DAY YEAR October 19, 1982 | | 2b. HOUR 8:05 P ^M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 29 30 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County ^{MD.} | | |
| 10. CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | | 12b. KIND OF BUSINESS OR INDUSTRY U-Haul Co. of Md. | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Middle River | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 13e. STREET ADDRESS 1109 Wampler Rd. 21220 | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ernest Leo Polk, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ellender McCullough | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes Korean | | | 16b. SOCIAL SECURITY NO. 220-24-4332 | | 17. INFORMANT ADDRESS Mrs. Betty J. Polk Balto., Md. 21220 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH within 2 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 7 , 19 77 , to Oct. 19 , 19 82 , that (I) (we) lost saw the deceased alive on August 24 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Dr. Teodulo Paglinauan DEGREE | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10-21-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Teodulo Paglinauan | | | | 22e. ADDRESS 8552 Philadelphia Rd., 21237 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-23-82 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hills Mem. Gard. Baltimore, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home 7401 Belair Rd. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 29 1982 | | | | |

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NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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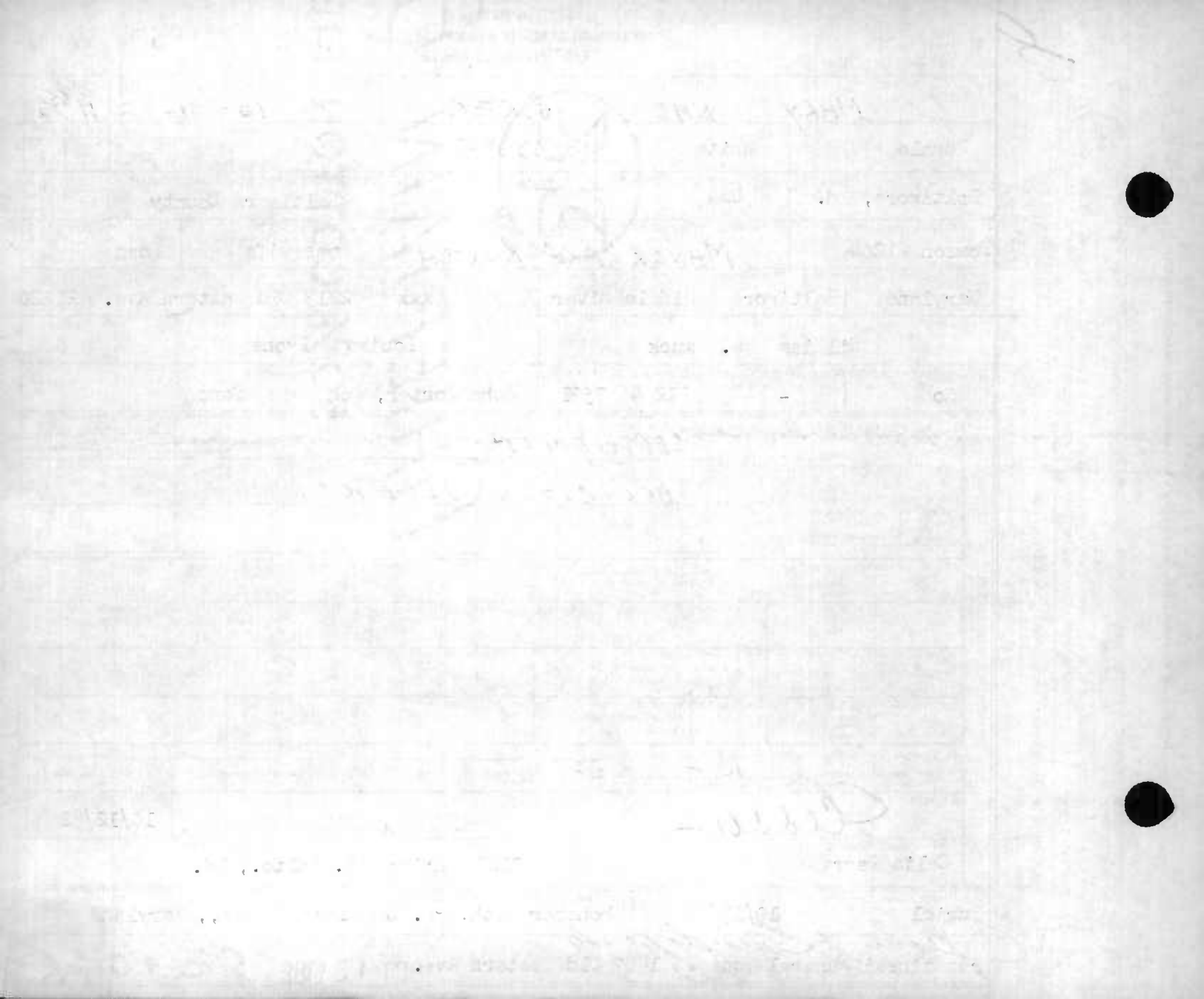
REG. NO.

1 - FOR
STATE
REGISTRAR

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|---|--|---|--|--|--|---|--|-----------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| MARY | | NMI | | PORTER | | 10-11-82 | | 11:55 AM | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Female | | White | | May 13 1896 | | 86 | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Baltimore, Md. | | USA | | | | Baltimore County MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Towson 21204 | | MANOR CARE RUXTON | | Housewife | | Home | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | |
| Maryland | | Baltimore | | Middle River | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2213 Old Eastern Ave. 21220 | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| William E. Smuck | | Louise Lyons | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | ADDRESS | | | |
| No | | 212 46 7591 | | John Porter, Son | | Same | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 7070 DUE TO, OR AS A CONSEQUENCE OF (b) DECUBITUS ULCERS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on 10-19-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| Celia Parra | | | | 10/12/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Celia Parra | | 7122 Harford Rd. Balto., Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 10/13/82 | | Ebenezer Meth. Ch. Cemetery | | Chase, Maryland STATE | | | |
| 24 FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Brudzinski Funeral Home | | 1407 Old Eastern Ave | | OCT 15 1982 John J. Conner | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1
(VRA 15, 4)



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 5 2 9 9 | | | |
|---|--|--|--|---|--|---|--|
| 1. STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sydney Wynne Porter | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-28-82 | | 2b. HOUR 2 P M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 27, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2225 Rogene Dr Apt 101X | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adv.Exec. | | 12b. KIND OF BUSINESS OR INDUSTRY Sun Paper | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2225 Rogene Dr 21209 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander Shaw Porter | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Keen | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-03-2731 A | | 17. INFORMANT ADDRESS Geoffrey A. Porter 2225 Rogene Dr 21209 | | | |
| 18. CAUSE OF DEATH (Enter only one cause but list all in 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 2384 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> (c) <u>Intermittent Hypertensive Cardiovascular Disease</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>30 years ago</u> to <u>1982</u> , that (I) (we) last saw the deceased alive on <u>27 Oct 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Dr. Louis P. Hamburger</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 29 Oct '82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Louis P. Hamburger | | | | 22e. ADDRESS 100 McHenry Rd | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-1-82 | | 23c. NAME OF CEMETERY OR CREMATORY St. Geo. Episcopal Ch. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Perryman Harford Maryland | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Rd 21212 ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR NOV 8 1982 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 2 5 3 0 0
REG. NO.

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|---|--|---|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) SOPHIA SOPHIE PRIGAL | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-22-82 | | | 2b. HOUR 9:00 AM | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 5, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN RANDALLSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 9435 EDWAY CIR. #21133 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HERMAN ISRAEL BERNSTEIN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 218-26-0209 | | 17. INFORMANT ADDRESS MR. ARNOLD PRIGAL 9345 EDWAY CIR. RANDALLSTOWN MD 21133 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure 4589 DUE TO, OR AS A CONSEQUENCE OF (b) Hypotension due to above DUE TO, OR AS A CONSEQUENCE OF (c) cause Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hours 24 Hours | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-21-1982 to 10-22-1982 that (I) (we) last saw the deceased alive on 10-22-1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Soon Chul Hong | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10-22-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOON CHUL HONG | | | | | | 22e. ADDRESS Baltimore County General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE OCT. 24, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL ANSHE KOLK | | 23d. LOCATION CITY OR TOWN COUNTY BALTIMORE MARYLAND | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 27 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | |

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 0 1

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Walter W. PROTISKI | | | 2a. DATE OF DEATH MONTH DAY YEAR October 18, 1982 | | 2b. HOUR 5:40 A.M. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 7 9 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.S.R. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Rossville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Natl. Machine Operator | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Dundalk | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Protiski | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anastacia | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1932-1934 | | 17. INFORMANT ADDRESS Frances M. Hewitt 4802 Vicky Road Balto., MD. 21236 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Metastatic Lung Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (s) (this hospital) attended the deceased from September 2, 19 82, to October 18, 19 82, that (we) last saw the deceased alive on October 18, 19 82, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Donald R. Richter MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. Richter | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10.20/1982 | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222 | | | 25a. DATE REC'D. BY REGISTRAR OCT 19 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Chief |

RECEIVED

1944



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 0 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Augusta Mary Pumphrey | | | 2a. DATE OF DEATH MONTH DAY YEAR October 5, 1982 | | | 2b. HOUR 11:30 AM | | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Schmidt | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Frick | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 218-52-0706 | | 17. INFORMANT ADDRESS Miss Ruth Pumphrey 809 St. Dunstons Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 5 ± yrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/2/82 to 10/5/82, that (I) (we) last saw the deceased alive on 10/2/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Charles O'Donnell, M. D. | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 10/6/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles O'Donnell, M. D. | | | 22e. ADDRESS 7501 York Road Baltimore, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd. | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 11 1982 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Blank document with faint horizontal lines and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 (REV. 7-79) is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 5 3 0 3 REG. NO. | | | |
|---|--|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH M. RAABE | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 30 '82 | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR Sept 18, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION GBMC-6701 N. CHARLES ST. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Parkville | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Roland | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Spicer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 215-07-7735 | | 17. INFORMANT ADDRESS Mrs JOan Howard Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1809 IMMEDIATE CAUSE (a) CARDIOPULMONARY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CERVICAL CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OLD AGE | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-27 , 19 82 , to 9-30 , 19 82 , that (I) (we) last saw the deceased alive on 9-29 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Henry H. Startzman MD | | | | 22c. DATE SIGNED 9-30-82 | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY H. STARTZMAN, 111 MD. | | | | 22f. ADDRESS GBMC-6701 N. CHARLES ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 10/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR OCT 1 1982 | | 25b. REGISTRAR'S SIGNATURE John R. Baird | |

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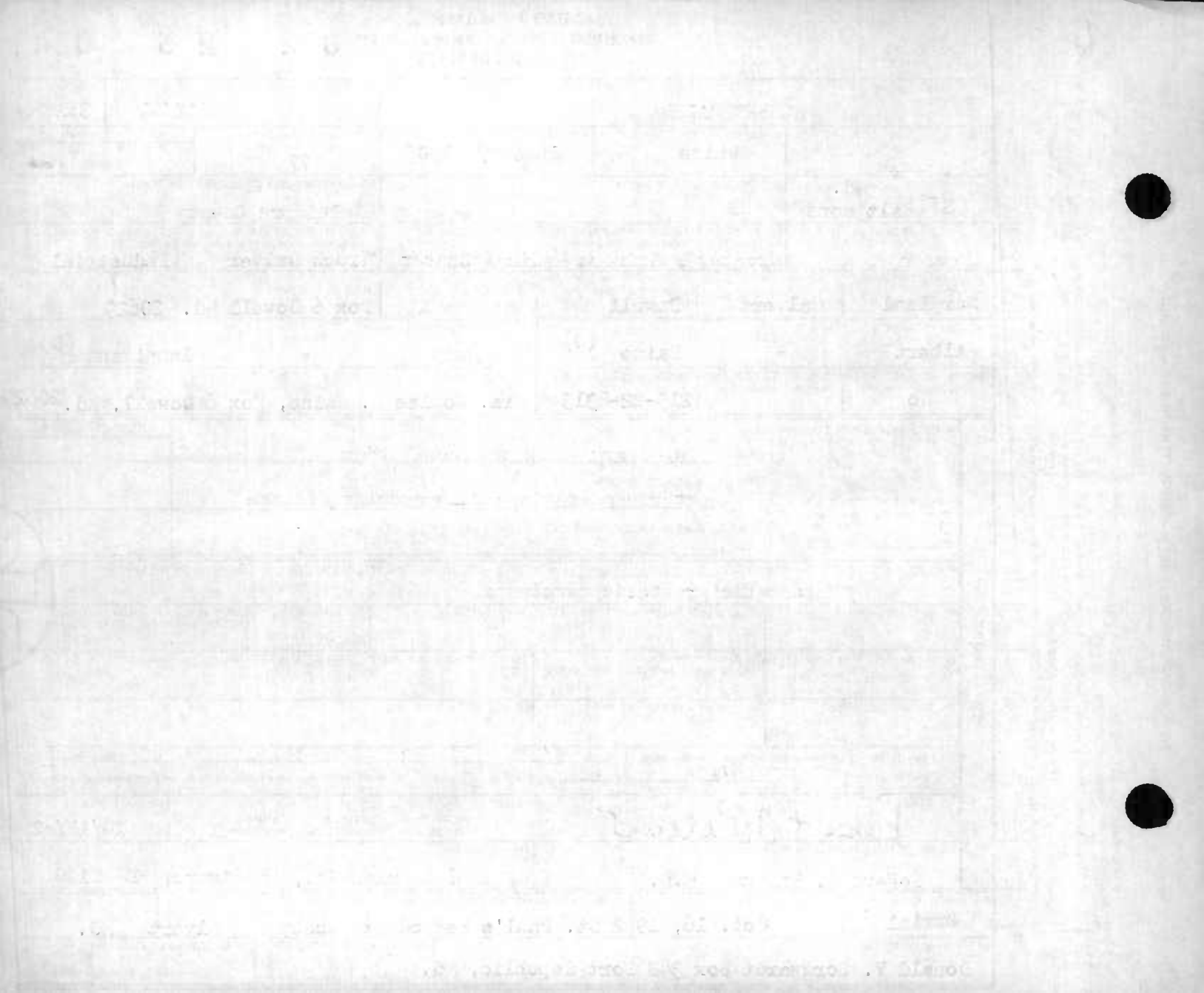
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 3 0 4 REG. NO. | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT RAINE | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10/12/82 | | | | 2b. HOUR 3:10P_M | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH June 9 1905 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) US Baltimore | | | 7b. CITIZEN OF WHAT COUNTRY? US | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | | 12b. KIND OF BUSINESS OR INDUSTRY Industrial | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Calvert | | | 13c. CITY OR TOWN Dowell | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS Box 6 Dowell Md. 20629 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert - Raine (D) | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary - Flannigan (D) | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 215-22-8313 | | | 17. INFORMANT ADDRESS Mrs. Louise L. Raine, Box 6 Dowell, Md. 20629 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Pulmonary edema and congestion | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Metastatic prostatic carcinoma | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/23 , 19 82 , to 10/12 , 19 82 , that (I) (we) lost saw the deceased alive on 10/12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Robert A. Palermo DEGREE | | | | | | | | | | 22c. DATE SIGNED 10/13/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Palermo, M.D. | | | | | | | | | | 22e. ADDRESS 6701 N. Charles St., Baltimore, MD 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Oct. 16, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Methodist | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lusby Calvert Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Donald V. Borgwardt | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 19 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 0 5

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Herman R. Rammes | | | 2a. DATE OF DEATH MONTH DAY YEAR October 16, 1982 | | 2b. HOUR 4:21 AM | | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb 21, 1900 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 82 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Joseph Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MARKING LIFE) Retired Mill Hand | | 12b. KIND OF BUSINESS OR INDUSTRY Md Biscuit Cp | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Rammes | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna ? ? | | 13e. STREET ADDRESS 7207 Old Harford Rd | | 13f. CITY OR TOWN 21234 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-09-6710 | | 17. INFORMANT Mrs Jeanette A Rammes | | ADDRESS Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for Part I. Death was caused by: IMMEDIATE CAUSE (a) Respiratory Distress 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Severe Pneumonia (c) Chronic Obstr. Pul. Disease | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Arteriosclerotic Heart Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 11, 1982 , to October 16, 1982 , that <input checked="" type="checkbox"/> (we) lost <input checked="" type="checkbox"/> saw the deceased alive on October 16, 1982 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Ruben S. Sebastian M.D. | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ruben S. Sebastian M.D. | | 22e. ADDRESS 7620 York Road Towson, Maryland 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR OCT 19 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canier | |

October 16, 1982 4:21 PM

Thomas

R.

Thomas

Baltimore County

Saint Joseph Hospital

Township

October 16 82

October 11 82

82

October 16

7630 York Road, Towson, Maryland 21204

Robert S. Sebastian M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE B. RAUB | | | | | 2a. DATE OF DEATH MONTH October DAY 12 YEAR 1982 | | 2b. HOUR 1:22a M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH March DAY 13 YEAR 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 | | IF UNDER 1 YEAR MONTHS DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tally Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Steel Mfrgr. | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST George MIDDLE B. LAST Raub | | | | | 15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE LAST Keating | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS Lucia L. Raub (Wife) Same as 13c | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4920 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Emphysema with Fibrosis and Right DUE TO, OR AS A CONSEQUENCE OF (c) Lower Lobe Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 20 , 19 82 , to October 12 , 19 82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 12 , 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE David Ginn | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 10/12/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Ginn | | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 10/12/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE | | | |
| 24. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk, Md. 21222 | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 13 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Ginn | | | |

W

UNION WATER

1000 1000 1000 1000

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MEDICAL EXAMINER RELEASED

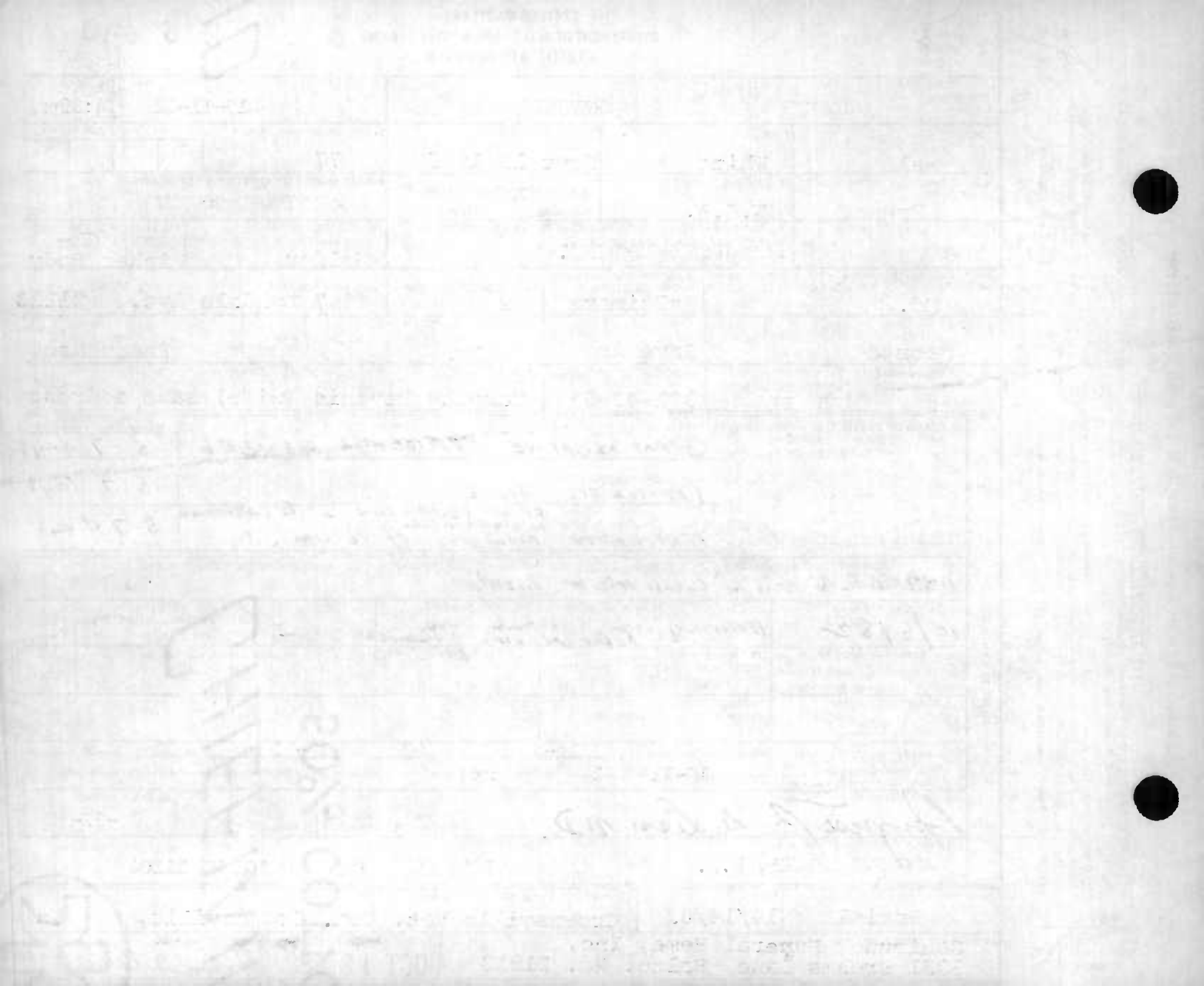
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 5 3 0 7 REG. NO. | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH RAVENIS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-11-82 | | | | 2b. HOUR 4:39pm | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept 15 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder | | 12b. KIND OF BUSINESS OR INDUSTRY GM-Fisher Body | |
| 13a. STATE Md. | | | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Ravenis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Radauskas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. WW II 381-03-6338 | | 17. INFORMANT ADDRESS Dorothy Ravenis (wife) same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1534 GRAM NEGATIVE SEPTICEMIA, SEVERE DUE TO, OR AS A CONSEQUENCE OF (b) PERITONITIS, ACUTE DUE TO, OR AS A CONSEQUENCE OF (c) PERFORATION, MULTIPLE OF CECUM, 1 FROM OBSTRUCTION 2" TO CARCINOMA OF SIGMOID | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-7 days 5-7 days 5-7 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ARTERIOsclerotic changes, Cardiovascular Disease | | | | | | | | | |
| 19a. DATE OF OPERATION 10/6/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATION Cecum obstruction from ARTERIO CARCINOMA of SIGMOID | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-5 19 82, to 10-11 19 82, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-11 19 82, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Augusto B. de Leon MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10-12-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AUGUSTO DELEON, M.D. | | | | 22e. ADDRESS 7620 YORK ROAD TOWSON MD 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial. | | 23b. DATE 10/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md | | | |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 13 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 0 8 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DONALD B RAVER Jr | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/30/82 | | 2b. HOUR 7:45 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR December 8, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 51 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N CHARLES ST GBMC | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) FIRST MIDDLE LAST Maryland Carroll Westminster | | 13b. CITY OR TOWN Westminster | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 21157 198 E. Green St Westminster Md | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Donald B Raver Sr | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly B Winterstein | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO. 218-26-9789 | | 17. INFORMANT ADDRESS Mrs Loretta L Raver Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: CARDIAC ARREST 1629 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) LUNG CANCER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/24 , 19 82 , to 9/30 , 19 82 , that (I) (we) last saw the deceased alive on 9/30 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE T. Firth MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/30/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR T. FIRTH | | 22e. ADDRESS GBMC Towson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 4 1982 [Signature] | | | |

ALBERTA

EDWARD RAY

ALBERTA COUNTY

701 W CHARLES ST EDM

EDMONT

CARDIAC ARREST

TESTIMONY BY ARREST

L. M. CAMER

1930

1930

1930



1930

GR. T. H. H.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Troy

Ray

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 10 2 19 82 2b. HOUR 5:30 a M

3 SEX

Male

4 RACE

Negro

5. DATE OF BIRTH

March 31, 1962

6. AGE (IN YEARS LAST BIRTHDAY)

20 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR 10 2 19 82

2d. HOUR 5:30 a M

7a. BIRTHPLACE (STATE OR

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County, MD.

10. CITY OR TOWN OF DEATH

Baltimore County

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Interstate 83

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Truck driver

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. COUNTY Calvert

13c. CITY OR TOWN Huntingtown

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS Box 466 Huntingtown, MD 20639

14. FATHER'S NAME

John

MIDDLE

Ray

15. MOTHER'S MAIDEN NAME

Delores

MIDDLE

Scott

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

217-88-9413

17. INFORMANT

ADDRESS

Delores Ray Box 466 Huntingtown, MD 20639

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

8120 IMMEDIATE CAUSE (a) Fractured neck

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR 5:15xx10 2 19 82

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Driver in tractor/trailer/tractor/trailer Impacted

21d. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

street

21f. LOCATION

Interstate 83

CITY OR TOWN

COUNTY

Baltimore, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

Thomas D. Smith

TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER

DATE SIGNED 10/2/82

EXAMINER'S NAME (TYPE OR PRINT)

Thomas D. Smith, MD.

ADDRESS

111 Penn St. Balto., Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Oct. 6, 1982

23c. NAME OF CEMETERY OR CREMATORY

Patuxent Chr. Cem.

23d. LOCATION

Huntingtown

COUNTY

Calvert MD

24. FUNERAL DIRECTOR

NAME

Spencer E. Sewell Box 31 Prince Fred. MD 20678

ADDRESS

25a. DATE REC'D. BY REGISTRAR

OCT 6 1982

25b. REGISTRAR'S SIGNATURE

John J. Connel

STATE OF MARY AND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 1 0

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN H REICHERT | | | 2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 14, 1982 | | | 2b. HOUR P 8:00 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 14 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO. OF INSTITUTION GIVES ITS ADDRESS) ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assemblyman | | 12b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal | |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN PERRY HALL | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John W. Reichert | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertie Steg | | | 13e. STREET ADDRESS 4110 Perry View Rd. 21236 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11 213-03-5732 | | 17. INFORMANT ADDRESS Mr. Wilbur Steg 4110 Perry View Rd. Balto., Md. 21236 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause for immediate death) PART I. DEATH WAS CAUSED BY: 1519 RESPIRATORY ARREST IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CARCINOMA OF STOMACH DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of Stomach PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/11 , 19 82 , to 10/14 , 19 85 , that (I) (we) last saw the deceased alive on 10/14 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE E. Friedman | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (IF CURRENTLY) | | | 22e. ADDRESS 25 Perry Ln Balto, Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home | | | ADDRESS 7401 Belair Rd | | 25a. DATE REC'D. BY REGISTRAR OCT 18 1982 | | 25b. REGISTRAR'S SIGNATURE Seal | | |

The medical examiner must be notified of a death.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a death.

JOHN W. REID
OCTOBER 14, 1932

MALE
WHITE
BORN IN 1892
ST. LOUIS, MISSOURI

ST. LOUIS HOSPITAL
ST. LOUIS, MISSOURI
ST. LOUIS, MISSOURI
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 72 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 1 1

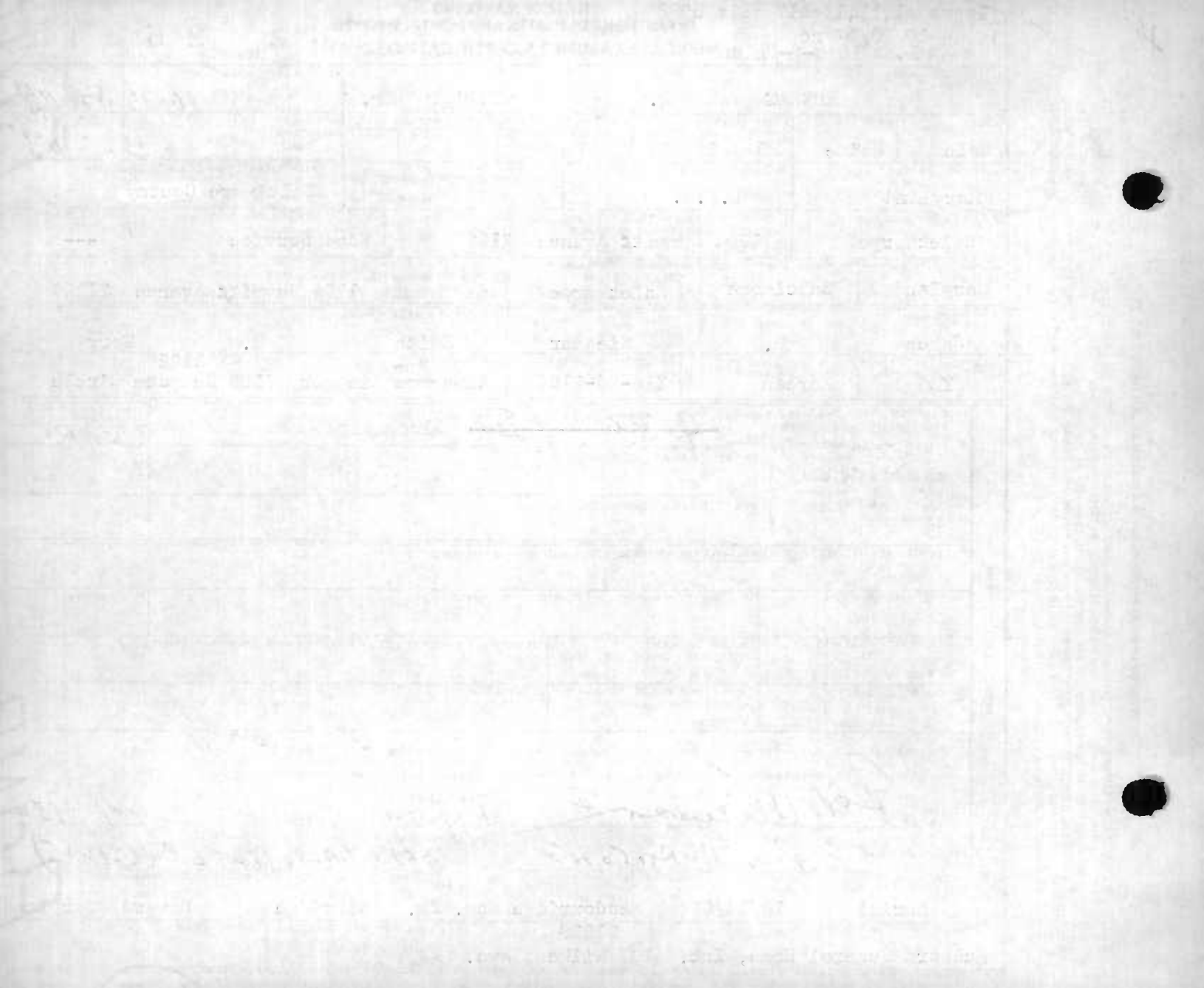
1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRMA E RICHTER | | | 2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 23, 1982 | | 2b. HOUR 1:00 AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 11 19 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH TOWSON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife & RN | 12b. KIND OF BUSINESS OR INDUSTRY nursing & homemaking | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS 7005 Eastern Ave. 21224 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Wolf | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida M. Conn | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-10-9502 | 17. INFORMANT ADDRESS 7005 Eastern Ave. Dr. Christian F. Richter (21224) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1952 CARDIORESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED CARCINOMATOSIS OF ABDOMEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 09/29, 19 82, to 10/23, 19 82, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/23, 19 82, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did <input type="checkbox"/> view the body after death. | | | | | |
| 22b. SIGNATURE Gopal Guruswamy MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GOPAL GURUSWAMY MD | | 22e. ADDRESS 7620 YORK RD BALTO., MD. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 10-26-82 | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME LASSAHN F.H. | | ADDRESS 7401 BELAIR Rd | | 25a. DATE REC'D. BY REGISTRAR OCT 28 1982 | 25b. REGISTRAR'S SIGNATURE John J. [Signature] |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | | | | | | | |
|--|--|----------------------|--|--|--|---|--|--|--|---|--|--|--|
| Items #1,11,13e&17 Film G572 FOR 10/20/82 1- STATE REGISTRAR Item 18 6-8-84 cr DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 2 2 5 3 1 2 | |
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT D. RIEGGER Sr. | | | | | | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH 10 DAY 13 YEAR 1982 | | 2b. HOUR 11:50 M A | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 1 DAY 30 YEAR 30 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 10 13 19 | | 2d. HOUR 11:50 M A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Halethorpe | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1704 Summitz Avenue 21227 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food Service | | | | 12b. KIND OF BUSINESS OR INDUSTRY --- | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Halethorpe | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1704 Summitz Avenue 21227 | | | |
| 14. FATHER'S NAME FIRST James MIDDLE M. LAST Riegger | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Edith MIDDLE M. LAST Tarr | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. 214-26-2196 | | 17. INFORMANT Anna Mae Riegger | | | | ADDRESS 21228 6502 Redgate Circle | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.S.E. A.D. Alcoholism DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3030 | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE E.P. Williamson | | | | M.D. D. Murphy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 10/13/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) E.P. Williamson | | | | ADDRESS 5550 BALTO NAT'L PK (CIVIL) | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | | | | 23d. LOCATION CITY OR TOWN Elkridge COUNTY Howard STATE Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. ADDRESS 4107 Wilkens Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 15 1982 | | 25b. REGISTRAR'S SIGNATURE J. Smith | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed in the office of the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 1 3
REG. NO.

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Carrie A Robertson | | | 2a. DATE OF DEATH MONTH DAY YEAR October 17, 1982 | | 2b. HOUR M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH 21219 Edgemere | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9105 B avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Dept. Store |
| 13a. STATE Md. | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Edgemere | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hammond Thompson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sue Golden | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 216 01 3759 | | 17. INFORMANT ADDRESS Terri Phillips 9105 B avenue 21219 (Daughter) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 10 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-1 , 19 58 , to 10-17 , 19 82 , that (I) (we) last saw the deceased alive on 10-6 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John V. Conway MD | | DEGREE | | 22c. DATE SIGNED 10/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John V. Conway MD | | 22e. ADDRESS 3401 Dundalk Ave Balt MD 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial | | 23b. DATE 10-20-82 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Rossville Balto. Md. | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE OCT 20 1982 John J. Connel | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 5 3 1 4 | |
|--|--|--|--|--|---|--|---|--------------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST | | | | | | | | | | MONTH DAY YEAR | |
| EMMA Margaret ROEMER | | | | | | | | | | 10-4-82 9 20 M | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | | White | | MONTH DAY YEAR | | | 79 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | U.S.A. | | | | | Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Randallstown | | | Baltimore County General Hosp. | | | | | | | HOMEMAKER | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | |
| Maryland | | | | | | | | | | Baltimore | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST | | | | | | | | | | FIRST MIDDLE LAST | |
| Charles Beyer | | | | | | | | | | Augusta Zickel | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | |
| No | | | | | | | | | | 220.18.9642 | |
| 17. INFORMANT | | | | | | | | | | ADDRESS | |
| Evelyn A. Simino | | | | | | | | | | 8605 Gray Fox Rd. Randallstown, Maryland 21133 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>with heart failure</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>congestive cardiomyopathy</i> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | | |
| <i>Diabetes mellitus</i> | | | | | | | | | | | |
| <i>bilateral pulmonary emphysema</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | CITY OR TOWN COUNTY STATE | | | | | |
| AT WORK AT WORK | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-13-1982</i> to <i>10-4-1982</i> , that (I) (we) lost | | | | | | | | | | | |
| saw the deceased alive on <i>10-4-1982</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | |
| <i>Soon Chul Hong</i> | | | | | | | | | | <i>10-4-82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | |
| SOON CHUL HONG | | | | | | | | | | Baltimore County General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | 23e. COUNTY STATE | |
| Cremation | | | 10/5/1982 | | Green Mount Crematory | | | Baltimore | | Maryland | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | |
| Walter Brooks Bradley Inc., Balto., Md. 21222 | | | | | | | | | | OCT 5 1982 | |
| | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | | | | | <i>John J. Carver</i> | |

EMMA - 20-7-26

TO THE
MAYOR OF
LONDON

FROM
THE
LONDON COUNTY COUNCIL

IN
REPLY TO
YOUR LETTER OF 20-7-26

YOUR LETTER OF 20-7-26
HAS BEEN RECEIVED

AND THE MATTER
IS BEING CONSIDERED

BY THE
COUNCIL

YOUR LETTER OF 20-7-26
HAS BEEN RECEIVED

AND THE MATTER
IS BEING CONSIDERED

BY THE
COUNCIL



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 1 5

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | October 4, 1982 | | 4:10 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| F | | W | | 3/12/96 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Balto. Md. | | U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Balto. | | Franklin Square Hos. | | Sales Lady | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. INSIDE CITY LIMITS? | | 13b. STREET ADDRESS | |
| Retired | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 801 Brunswick rd. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | |
| Stevens | | ? | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 066/18/8161 | | Michael Romano | | 801 Brunswick Rd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 3109 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } Anorexia and wasting (b) } (c) } DUE TO, OR AS A CONSEQUENCE OF Organic brain syndrome | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from Sept. 21, 19 82, to Oct. 4, 19 82, that (we) lost the deceased alive on Oct. 4, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Dr. Bligard | | | | Oct 4 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | |
| Dr. Bligard | | 9000 Franklin Square Dr., 21237 | | OCT 6 1982 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9/9/82 | | Lineawn | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME | | OCT 6 1982 | | John J. Carver | |

MEDICAL CERTIFICATION

2
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

3



SEAME

SHAVE



THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, this medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 2 5 3 1 6 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | ARTHUR JOHN ROTHCHILD | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| ARTHUR JOHN ROTHCHILD | | | | | | 10 17 82 | | 9 40 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| MALE | | WHITE | | 9/10/1900 | | 82 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| NEW YORK | | U.S.A. | | | | BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| PIKESVILLE | | 2 MONTAIGNE CT. APT. 2A. | | | | CRANE OPERATOR | | STEEL MFGR. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MARYLAND | | ----- | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 138 S. HIGHLAND AVE. 21224 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| EMIL ROTHCHILD | | | | UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| YES | | | | W.W.1 | | 213.07.8018 WILLIAM M. McFADDEN, JR. SAME AS 11. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| 1629 IMMEDIATE CAUSE (a) Brain Metastasis | | | | | | | | | 2 weeks. |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | 3 mm. |
| (b) LUNG Ca | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10. | | | | | | | | | |
| ASCD | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | CITY OR TOWN COUNTY STATE | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 10/7/82, 19 82, to 10/17, 19 82, that (1) (we) lost saw the deceased alive on 10/10, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| S.H. MALINOW | | | | MD | | | | 10/17/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| S.H. MALINOW | | | | 3536 OLD COURT RD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN COUNTY STATE | |
| BURIAL | | 10/20/1982 | | OAK LAWN CEMETERY | | BALTO. | | MD. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 | | | | OCT 18 1982 | | John J. Casper | | | |

10-20



[Faint, mostly illegible handwritten text and markings covering the majority of the page. Some words like "copy" and "original" are faintly visible.]

001-84001 0-1-100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

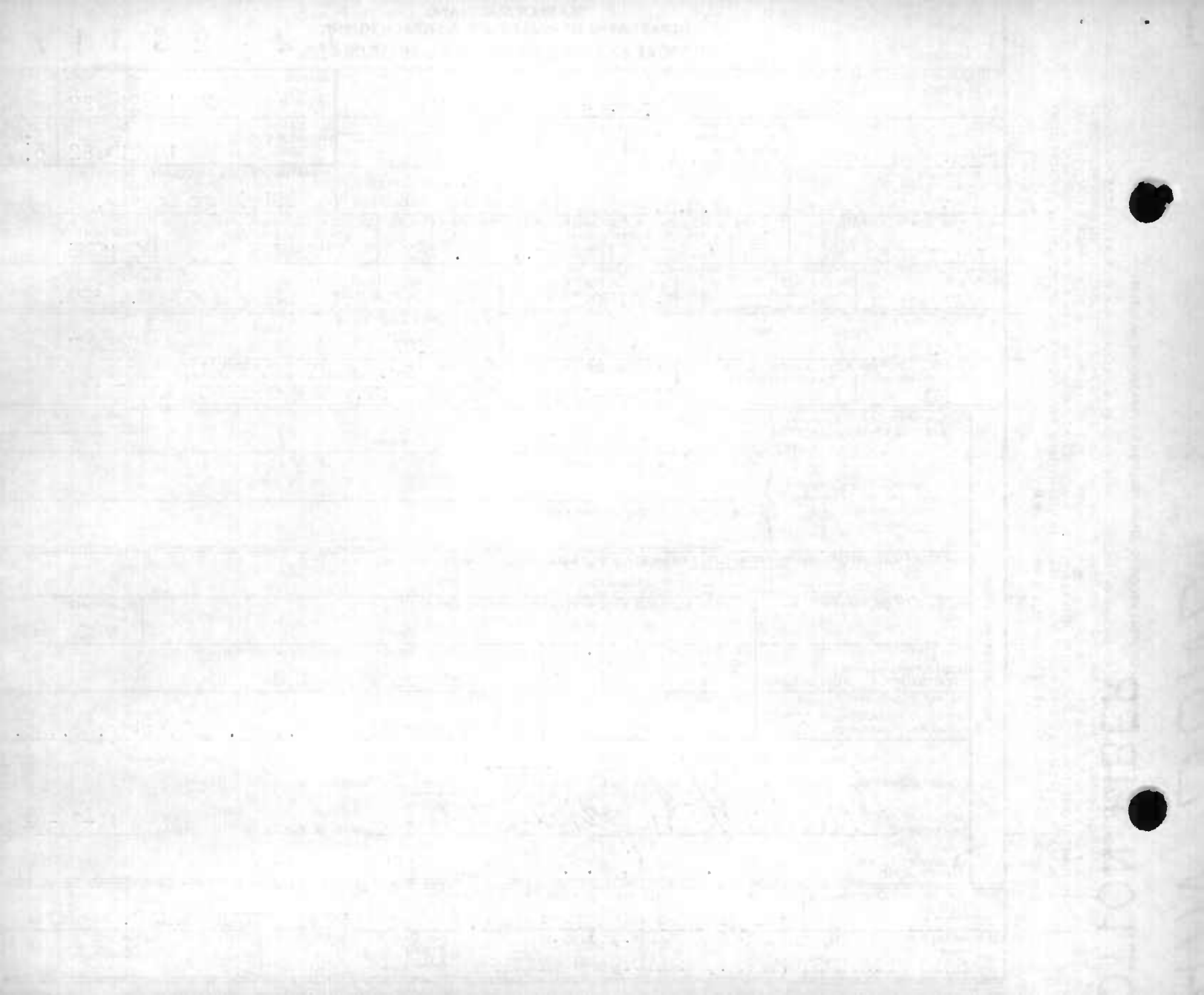
BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|---------|--|---------|--|-------------------------|---|------------------|--|--------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2b. DATE KNOWN OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Tanea | | | MICHELE | Rothschild | XX | | 10 | 21 | 1982 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
| FEMALE | WHITE | JULY 21, 1947 | | 35 YRS. | | | | | 10 21 1982 | 3:13 P. M. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MARYLAND | | U.S.A. | | Baltimore County, MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | 6501 Copper Ridge Dr., Apt. 202 | | | | HOUSEWIFE | | AT HOME | | |
| 13a. STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| MARYLAND | | BALTIMORE | | BALTIMORE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | #21209 6501 COPPER RIDGE DR., APT. 202 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| BENJAMIN | | CALESTA | | NO | | 212-50-1028 | | DR. HENRY ROTHCHILD 705 PINE ST., NEW ORLEANS, LA 70118 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> 9630 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Puncture Wounds of Chest</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY (est.) HOUR A.M. MONTH DAY YEAR ? P.M. 10 21 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject was strangled | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6501 Copper Ridge Dr., Apt. 202, Balto. Co., Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | | DATE SIGNED | |
| Dennis F. Smyth, M.D. | | 111 Penn Street | | | | | | | 10-22-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| BURIAL | | 10-24-82 | | HAR SINAI CONG. | | OWINGS MILLS BALTO. MD | | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | | | OCT 27 1982 | | John J. Connelley | | |



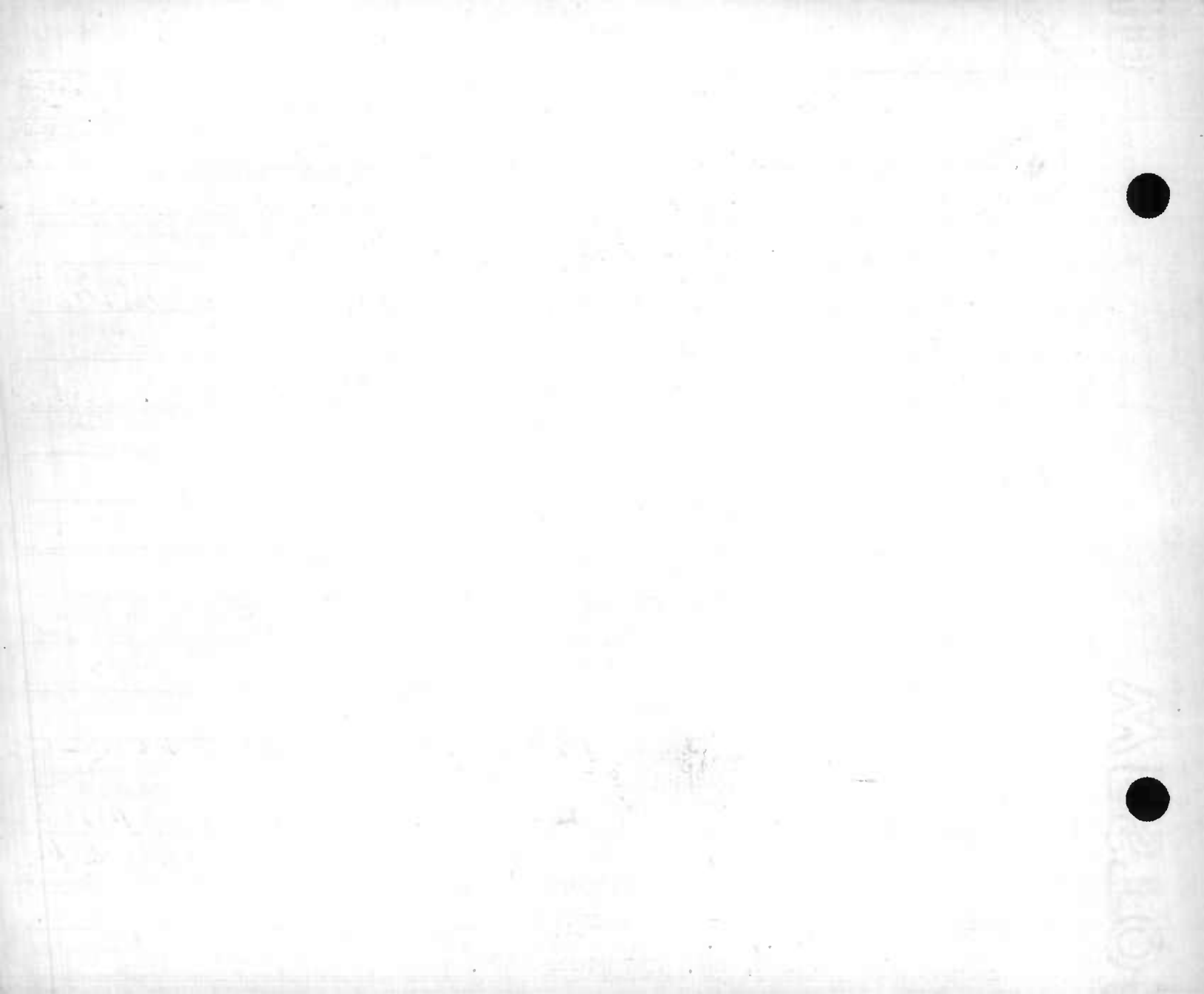
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified to examine the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 2 2 5 3 1 8 | | | | |
|---|--|--|---|--|---|--|---|--|---------------------------|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ADA E Rouse | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-25-82 | | | | 2b. HOUR 1:30 P.M. |
| 3 SEX Female | | 4 RACE Cauc | | 5. DATE OF BIRTH MONTH DAY YEAR 10 28 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Garrison | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrison Valley Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Liq. Packer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 441 Old Town mall 21202 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harris Enoch | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 223-03-1788A | | 17. INFORMANT ADDRESS Information from Clerk/Dr. Corbett | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4292 IMMEDIATE Cause (a) ASCVD | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978 to 02025 19 82 , that (I) (we) last saw the deceased alive on 02018 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] DEGREE MD | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 10/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. BOAS MD | | | | | 22e. ADDRESS 50 Scott ADAU RD Cockeysville MD 21030 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL | | 23b. DATE 10-28-82 | | 23c. NAME OF CEMETERY OR CREMATORY GREENLAWN | | 23d. LOCATION CITY OR TOWN COUNTY STATE BOWLING GREEN CAROLINE VA. | | | |
| 24. FUNERAL DIRECTOR NAME BALTO., MD. ADDRESS 21229 HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | | 25a. DATE RECD. BY REGISTRAR OCT 29 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

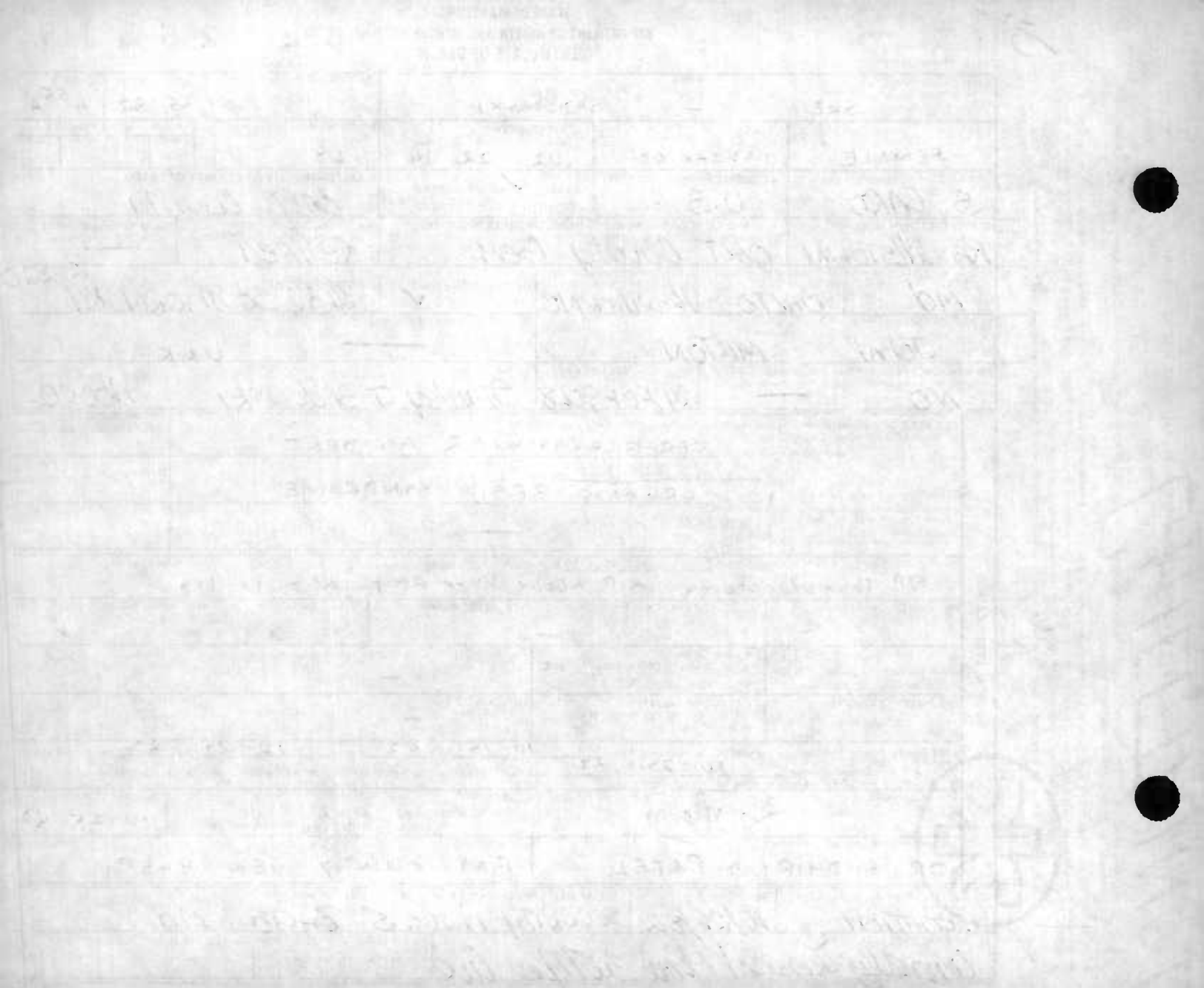
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 1 9

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) SUE - SADOWSKI | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 25 82 | | | 2b. HOUR 4 55 AM | | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASION | | 5. DATE OF BIRTH MONTH DAY YEAR 02 22 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CARO | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALT. COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALT. COUNTY GEN | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD. | | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN Hawthorne | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2132 Southorn Rd P. 220 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Milton | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 247-01-9068 | | 17. INFORMANT STANLEY J. SADOWSKI | | ADDRESS Above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 4360 DUE TO, OR AS A CONSEQUENCE OF (b) ORGANIC BRAIN SYNDROME DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): SIP Thyroidectomy SIP Above knee amputation Lt. Leg | | | | | | | | | | |
| 19a. DATE OF OPERATION - | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-25-1982, to 10-25-1982, that (I) (we) last saw the deceased alive on 10-25-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE S. PATEL | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10-25-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SUDHIR D. PATEL | | | | | 22e. ADDRESS BAL. COUNTY GEN. HOSP. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | 23b. DATE 10/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD. | | | |
| 24. FUNERAL DIRECTOR NAME Connolly Funeral Home | | | | | ADDRESS 3000 Ave | | 25a. DATE REC'D. BY REGISTRAR OCT 27 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 2 0

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|-----------------|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 10 | | 29 82 | |
| Adam | | Sakowski | | | | | | | | 1:50 P | |
| 2. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | White | | MONTH DAY YEAR | | 74 | | MONTHS DAYS | | HOURS MIN. | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U.S. | | | | Balto. County | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Garrison | | Garrison Valley Nurs. Ctr. | | Laborer | | Steel | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | | | Balto. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 204 S. Patterson Park Ave. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | |
| John | | Sakowski | | Katherine | | Sofinowski | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| Yes | | WWII | | 213-07-2908 | | Mrs. E. Presgrave | | Balto., Md. 21231 | | Av | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | 19. IMMEDIATE CAUSE (a) | | 19. IMMEDIATE CAUSE (b) | | 19. IMMEDIATE CAUSE (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1629 | | Lung Cancer | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| | | L. BOAS MD | | | | NOV 3, 82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| | | 50 SCOTT ADAM HQ Oakleyville rd 21030 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| Removal | | 10/29/82 | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Anatomy Board | | Balto., Md. | | NOV 9 1982 | | John J. Lohr | | | | | |

MEDICAL CERTIFICATION

0105

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1- STATE REGISTRAR | | REG. NO. 8 2 2 5 3 2 1 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN | | 2. LAST NAME SAPERSTEIN | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 3. SEX MALE | | 4. RACE Caucasian | | 5. DATE OF BIRTH JAN 1, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | | 7. MONTH DAY YEAR OCT 31 82 | |
| 7a. BIRTHPLACE (COUNTRY) BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERICAL | | 12b. KIND OF BUSINESS OR INDUSTRY AUTO. IND | |
| 13a. STATE MD. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN PIKESVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS APT 7-21208 23 STONEHEDGE CIRCLE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MAX | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA (UNKNOWN) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-22-5279 | | 17. INFORMANT ADDRESS MRS FRANCES SAPERSTEIN - 23 STONEHEDGE CIRCLE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Ac. Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASH D DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 min. 25 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): JAKOB-CRIBETZ FELD'S DISEASE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 59 to OCT 31 82, that (I) (we) last saw the deceased alive on OCT 31 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Daniel Bakal MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED OCT 31 82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL BAKAL | | 22e. ADDRESS 600 REISTERSTOWN RD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IS CRT) | | 23b. DATE NOV 1 82 | | 23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH | | 23d. LOCATION CITY OR TOWN COUNTY STATE WOOD LAWN MD. | | | |
| 24. FUNERAL DIRECTOR NAME SOL. LEVINSON & BROS | | 24b. ADDRESS 6010 REISTERSTOWN RD | | 25a. DATE REC'D. BY REGISTRAR NOV 4 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 2 | 5 | 3 | 2 | 2 | |
|--|--|--|---|--|--|---|---|--|--|--|---|---|---|--------------------------------|---------------------------|---|--------|
| 1 - STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | FIRST MIDDLE LAST Mary Catherine Scally | | | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR 10 19 1982 | | 2b. HOUR 10:45 | | A M |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR 03 20 1890 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH RANDALYSTOWN | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) OLD COURT NURSING CENTER | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Gaywood | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 231 Blenheim Rd. 21212 | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kilroy | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. unknown | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-5595 | | | 17. INFORMANT ADDRESS Katherine A. Barrick Same | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UROSEPSIS</u> <u>5990</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC NON-PAINE</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>27 JAN</u> , 19 <u>76</u> , to <u>19 OCT</u> , 19 <u>82</u> , that <u>X</u> (we) last saw the deceased alive on <u>10-19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>KATHER M. JENN M.D.</u> | | | | | DEGREE | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED 10/20 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS <u>3640 FORDS LANE 21215</u> | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 10/23/1982 | | | 23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Texas Balto Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 Yorl Rd. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 26 1982 | | | 25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u> | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|------------------|---|-------------------|--|--|---------------------------------------|-------------|---|-----------|---------------------------|------------|--|------------------|--|----------|--|--|--|--|------------------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Howard | | MIDDLE D. | LAST Schafer. | | 2a. DATE OF DEATH | | | | MONTH 10 | | DAY 26 | | YEAR 82 | | 7b. HOUR 0854 | | A. M. | | | | | | | | | | |
| 3. SEX Male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH AUG. 13, 1925 | | DAY | | YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 | | YRS. | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. DAYS | | HOURS | | MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSPITAL | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ANALYST | | 12b. KIND OF BUSINESS OR INDUSTRY US GOV'T. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 5516 NORTHGREEN RD. #21207 | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST CARL | | | | MIDDLE | | LAST SCHAFER | | 15. MOTHER'S MAIDEN NAME FIRST FANNIE | | | | MIDDLE | | LAST SAPPERSTEIN | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. WW11-A.FORCE 212-20-6444 | | | | 17. INFORMANT MRS. LOUISE SCHAFER 5516 NORTHGREEN RD. BALTO., MD 21207 | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>coronary artery disease (triple vessel by cath)</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: () APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET | | | | CITY OR TOWN | | | | COUNTY | | | | STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE G. Maffori | | | | | | | | | | | | | | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 10/25/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Maffori | | | | | | | | | | | | | | | | | | 22e. ADDRESS BALTO. CO. GEN. HOSP. - RANDALLSTOWN, MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE OCT. 27, 1982 | | | | 23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK | | | | 23d. LOCATION RANDALLSTOWN BALTO. MD | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE Nov 3 1982 | | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 2 4

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|-------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRENE M. SCHAFFER | | | 2a. DATE OF DEATH MONTH DAY YEAR October 29, 1982 | | 2b. HOUR AM PM 11:25 a | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 25 1952 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 29 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Edgemere | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ignatius Kozaczenco | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Loska | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 214-58-8124 | | 17. INFORMANT Earl S. Schaffer | | ADDRESS 7213 Waldman Ave. Balto., MD. 21219 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest; Renal Cell Carcinoma with Metastasis to Brain**

4275

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) _____

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from October 28 , 19 82 , to October 29 , 19 82 , that (we) lost above the deceased alive on October 29 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>D. Wadhwa</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. WADHWA | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/2/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222 | | | | 25. DATE REC'D. BY REGISTRAR NOV 4 1982 | | | |
| | | | | 26. REGISTRAR'S SIGNATURE <i>John J. G... ..</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 5 3 2 5 REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Anna M. SCHIFFLER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR October 5, 1982 | | | 2b. HOUR 4:32P M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5 15 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Roseville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Piano teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Self-employed | | | |
| USUAL RESIDENCE IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION: 13a. STATE Maryland 13b. COUNTY Balto. 13c. CITY OR TOWN Balto. Cty. | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET ADDRESS 521 Elmwood Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Emil Staehlin | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosina Dedderer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | | 16b. SOCIAL SECURITY NO. 212-20-40724 | | 17. INFORMANT Mrs. Carolyn A. Murray Balto. | | | ADDRESS 521 Elmwood Rd. 21236 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov 1 , 19 82 , to Nov 5 , 19 82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Nov 5 , 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Elissa G. Bashner, M.D. | | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10/5/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elissa G. Bashner, M.D. | | | | | | 22e. ADDRESS 9000 Franklin Square Dr., 21237 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home Inc. | | | | | | ADDRESS 7401 Belair Rd. 21236 | | 25a. DATE REC'D. BY REGISTRAR OCT 11 1982 | | REGISTRAR'S SIGNATURE John J. Lohr | |

BP

UNITED STATES
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text block containing several lines of typed information, mostly mirrored or bleed-through from the reverse side.]



Very truly yours,
[Illegible Signature]
Special Agent in Charge
[Illegible]
[Illegible text at the bottom of the page, including distribution and filing notations.]

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 20. DATE OF DEATH | | REG. NO. | | DAY YEAR | | 2b. HOUR | |
| Hilda | | M. | | Schleich | | 10 3 82 | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | MONTH DAY YEAR 10 9 10 | | 71 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U. S. A. | | | | Baltimore County MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Balto. | | 2401 Alma Road | | | | Housewife | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | Baltimore, Md. | |
| Md. | | Balto. | | Balto. | | | | 2401 Alma Rd. | | #21227 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Eugene | | | | | | Myrtle Mariner | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| | | | | 215-28-6399 | | 2401 Alma Road, Baltimore, Md. Mrs. Joan H. Schwartz #21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic advanced malignant brain disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of the lungs</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1629</u> months <u>years</u> <u>years</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Valvular heart disease</u> <u>years</u> | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | Merda | | 82 Sept 4 82 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 4</u> 19 <u>82</u> to <u>Sept 4</u> 19 <u>82</u> , that (I) (we) lost <u>the deceased</u> <u>above</u> <u>in (we) (did) (did not)</u> <u>the body</u> after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Henry Armanas M.D.</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>Sept. 4/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HENRY ARMANAS</u> | | | | | | 22e. ADDRESS <u>1934 Wilkens Ave. Balto. Md. 21227</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>10-6-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Howard Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>G. Truman Schwab, P.A.</u> | | | | | | 3512 Frederick Ave., #21229 | | 25a. DATE REC'D. BY REGISTRAR <u>OCT 6 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connelley</u> | |



Advised members of the group
that the meeting will be held
at the same place as last time
on the 22nd of the month.

22nd of the month
at the same place as last time
on the 22nd of the month.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 2 7 | | | |
|---|--|---|--|---|--|--|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Karl W. Schlitz | | | | 2a. DATE OF DEATH MONTH DAY YEAR October 15, 1982 | | 2b. HOUR A. MIN. 8 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn, N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | |
| 10. CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 230 Edridge Way | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Insur. Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. STREET ADDRESS 230 Edridge Way -21228. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Francis A. Schlitz | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosina - Gogel | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I | | 17. INFORMANT ADDRESS Cockeysville, Md. 21030. Paul R. Schlitz-14410 Cuba Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1949 , 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on August , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John A. Nesbitt Jr. | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10-18-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. NESBITT JR | | | | 22e. ADDRESS 1009 Frederick Rd, Catonsville Md 21228 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 10/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory- Baltimore, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Stirling Funeral Estate 736 Edmondson Ave. - Catonsville, Md. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 19 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Schuch | |

BP

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

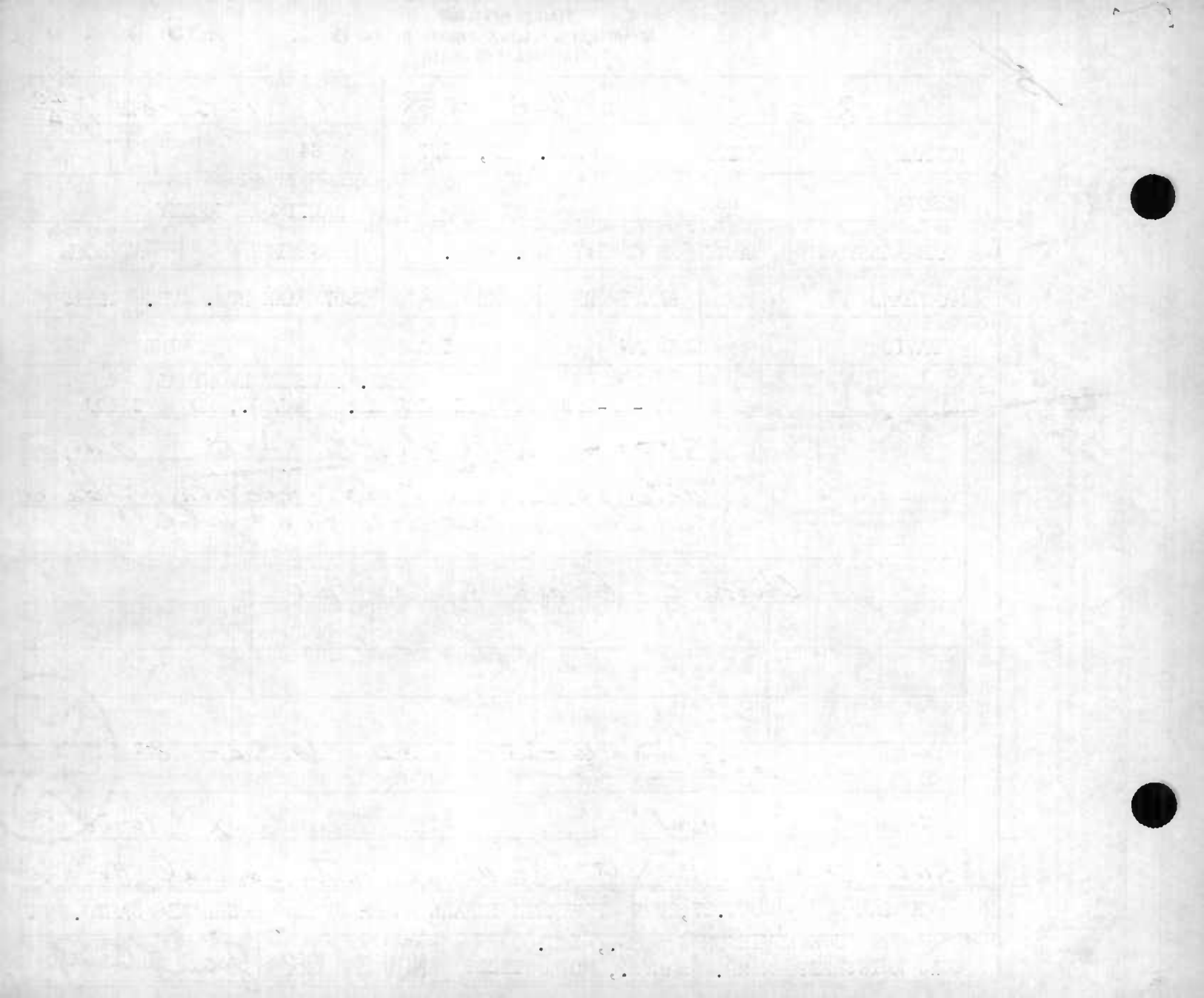
CERTIFICATE OF DEATH

8 2 2 5 3 2 8

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|---|--|--|--------|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST ROSE | MIDDLE | LAST SCHNAPER | 2a. DATE OF DEATH MONTH DAY YEAR 10-26-82 | | 2b. HOUR 7:40 ^{AM} | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH DEC. 25, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST DAVID SEIDMAN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA FINE | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-09-2938 | | 17. INFORMANT ADDRESS MRS. BEVERLY KRONTHAL 6600 PIMLICO RD. BALTO., MD 21209 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Sepsis with shock state days DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease years DUE TO, OR AS A CONSEQUENCE OF disease with heart failure (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic brain syndrome | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-25-1982 to 10-26-1982, that (I) (we) last saw the deceased alive on 10-26-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Soonchul Hong | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 10-26-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOONCHUL HONG | | | | 22e. ADDRESS Baltimore County General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE OCT. 27, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY TIFERETH ISRAEL ANSHE SPARD | | 23d. LOCATION ROSEDALE BALTO. MD | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR NOV 3 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 2 9

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie A Schoenlein | | | 2a. DATE OF DEATH MONTH DAY YEAR October 26, 1982 | | 2b. HOUR 3:04 AM | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR November 23, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Joseph Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Parkville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 8410 Nunley Dr 21234 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lorenz Schoenlein | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Oldewurtel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 578-03-5695 | | 17. INFORMANT Margaret M Lubehusen | | ADDRESS Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 12 hr 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Complete Disassociated rhythm, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Arteriosclerotic Cardiac Vase Dis | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) | | | | | | | | | |
| 19a. DATE OF OPERATION 10/25 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pacemaker | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/29/82 to 10/26/82 , that (I) (we) lost Dec 19 75 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, so state.) | | | | | | | | | |
| 22b. SIGNATURE Frank T Kasik | | | | DEGREE MD | | 22c. DATE SIGNED 10/26/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank T Kasik M.D. | | | | 22e. ADDRESS 9005 Harford Rd Baltimore, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland | | | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Oct 27 1982 John J. Casella | | | | | |

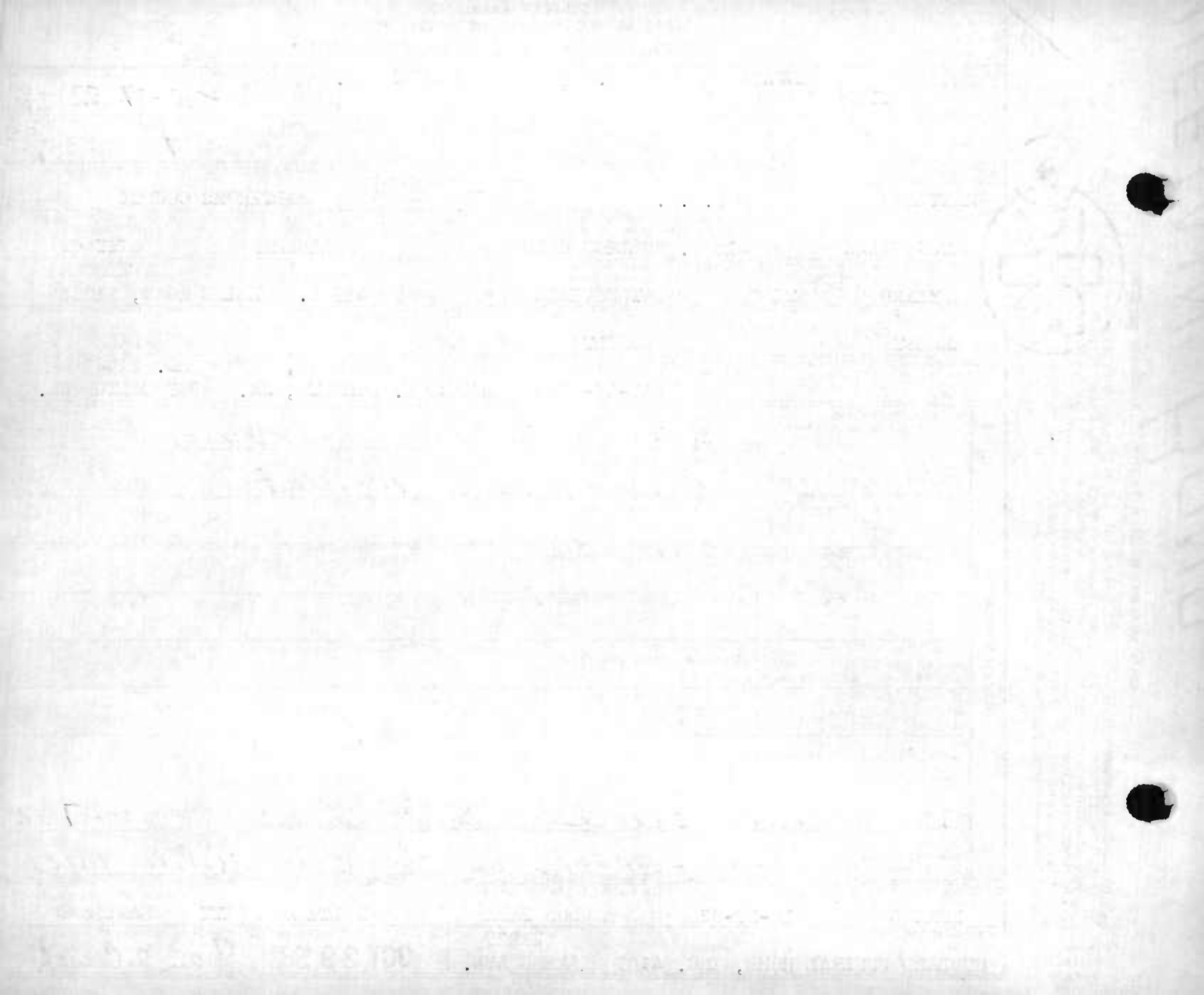
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25330 | |
|---|--|------------------------------|--|--|--|--|---|--|-------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edward H. Schultz | | | | | | | 2a. DATE KNOWN OF DEATH 10-27-82 | | 2b. HOUR 2:00 PM | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH 10-1-07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | 7c. DATE PRONOUNCED DEAD 10-27-82 | | 7d. HOUR 5:00 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 415 S. ROLLING ROAD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICEMAN | | 12b. KIND OF BUSINESS OR INDUSTRY CITY OF BALTIMORE | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN CATONSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 415 S. ROLLING ROAD, 21228 | | | |
| 14. FATHER'S NAME ERNEST SCHULTZ | | | | 15. MOTHER'S MAIDEN NAME LENA LEEK | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 217-46-2789 | | 17. INFORMANT COLUMBIA, MD. 21043 EDWARD H. SCHULTZ, JR. 4993 DALTON DR. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION _____ | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____ | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____ | | 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Conrado Ferrero | | | | | | TITLE (SPECIFY) Deputy | | MEDICAL EXAMINER | | DATE SIGNED 10-27-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) CONRADO FERRERO | | | | | | ADDRESS 5550 Balt NRP. Pike 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 10-30-82 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | 23d. LOCATION CITY OR TOWN BALTIMORE CITY COUNTY MARYLAND STATE _____ | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. ADDRESS 4107 WILKENS AVE. 21229 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 29 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 5 3 3 1 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | | | | |
| William Dennis Schwanke Sr | | | | | 09 29 82 | | | | |
| 3. SEX | | | | | 4. RACE | | | | |
| Male | | | | | White | | | | |
| 5. DATE OF BIRTH | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | |
| MONTH DAY YEAR | | | | | MONTHS DAYS HOURS MIN | | | | |
| 05 01 41 | | | | | 41 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | |
| Maryland | | | | | U.S.A. | | | | |
| 8. MARRIED <input checked="" type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | |
| Randallstown | | | | | retired | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore County General Hosp | | | | | SSA | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | | | | | | |
| Maryland Baltimore Gwynn Oak | | | | | | | | | |
| 14. FATHER'S NAME 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST FIRST MIDDLE LAST | | | | | | | | | |
| William Schwanke Sonia Drega | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS | | | | | | | | | |
| Yes (IF 1960-1962) 220-36-7566 Mrs Sonia Barnes 5108 Walther Blvd | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | |
| 4120 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| YES NO YES NO | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 21g. I certify that (I) (this hospital) attended the deceased from 9 19 81 to 9/29/81, that (I) (we) last saw the deceased alive on 9/29/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | | | |
| 22a. SIGNATURE DEGREE 22b. DATE SIGNED | | | | | | | | | |
| Raymond D Bahr M.D. 9/15/81 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) 22d. ADDRESS | | | | | | | | | |
| Raymond D Bahr M.D. Wilkins & Pine Heights Ave Baltimore, Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Burial 10/2/82 St Stanislaus Baltimore, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Leonard J Ruck Inc. Baltimore, Maryland OCT 1 1982 John J. Canine | | | | | | | | | |

MEDICAL CERTIFICATION



100-1-1000
100-1-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the registrar of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|---|--|
| 8 2 2 5 3 3 2 | | | | | | | | | | |
| 1 - FOR STATE REGISTRAR | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Gwendelyn G. Scott</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 21 82 | | | | | 2b. HOUR 9 ¹⁵ AM |
| 3. SEX <i>F</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH MONTH DAY YEAR 09 23 92 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 74 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County, MD</i> | | |
| 10. CITY OR TOWN OF DEATH <i>Ruxton</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MANOR CARE-RUXTON</i> | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Social Worker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13c. CITY OR TOWN <i>Baltimore</i> | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>101 W. Monument St.</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Townsend Scott</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Helen Evans</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | | | | 16b. SOCIAL SECURITY NO. <i>219 10 8465</i> | | 17. INFORMANT ADDRESS <i>Mr. Townsend Scott 6109 Bellinham Ct.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>4100 Pulmonary Edema.</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>4100 Pulmonary Edema.</i> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial INFARCTION.</i> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>0</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>C. E. PARRA</i> DEGREE | | | | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C. E. PARRA</i> | | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | | 23b. DATE <i>10/23/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Green Mount Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>MITCHELL-WIEDEFELD HOME, Inc.</i> ADDRESS <i>6500 York Road</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>OCT 25 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Cahill</i> | | |

1940-1941

1942-1943

1943-1944

1944-1945

1945-1946

1946-1947

1947-1948

1948-1949

1949-1950

1950-1951

1951-1952

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 2 2 5 3 3 3 REG. NO. | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edmund Smith Scull</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>October 10, 1982</i> | | | | 2b. HOUR M | | |
| 3. SEX <i>male</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>July 4, 1894</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>88</i> | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Randallstown</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Chapel Hill Nursing Home</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>expeditor, Beth. Steel</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <i>MD</i> | | 13b. COUNTY <i>Balto.</i> | | 13c. CITY OR TOWN <i>Reisterstown</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>4 South Lake Ct. 21136</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Samuel H. Scull</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine Veale</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-09-2610</i> | | 17. INFORMANT ADDRESS <i>Mrs. Wm. Rand (21136) Reisterstown, Md.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspirational Pneumonia</i> <i>3109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe Arteriosclerotic Organic Brain Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-13-</i> 19 <i>81</i> , to <i>10-10-</i> 19 <i>82</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>10-10-</i> 19 <i>82</i> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Dr. Cesar Valle Cervero</i> | | | | | DEGREE <i>M.D.</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <i>10-11-82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Cesar Valle Cervero</i> | | | | | 22e. ADDRESS <i>5310 Old Court Rd.</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>10/13/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City MD</i> | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Loring Byers Funeral Directors 8728 Liberty Rd. Randallstown, Md. 21133</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>OCT 11 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i> | | | |

BP

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

DATE: 10/10/61

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELLEN SELLMAN. | | | 2a. DATE OF DEATH MONTH 10 DAY 21 YEAR 82 | | | 2b. HOUR 8:20 A.M. | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH 6 DAY 23 YEAR 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) receptionist | | 12b. KIND OF BUSINESS OR INDUSTRY Insurance | | | |
| 13a. STATE Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Sykesville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1300 Third Ave | |
| 14. FATHER'S NAME FIRST Wesley MIDDLE Wright LAST Sellman | | 15. MOTHER'S MAIDEN NAME FIRST Virginia MIDDLE Berry LAST Donavin? | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-09-2366 | | 17. INFORMANT Virginia Arndt | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1990 IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent Small bowel fistula DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION 9-1-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent Small bowel fistula | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-4 19 82 , to 10-21 19 82 , that (I) (we) lost saw the deceased alive on 10-21 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Rayadurg Govindara | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10-21-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYADURG GOVINDARA | | 22e. ADDRESS BALTO COUNTY GENL HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 10/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR OCT 26 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | |

20th Century

1914-1918



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25335 | |
|---|--|-------------------------|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES RICHARD SEYMER | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED October 15, 1982 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1923 | | 6. AGE (IN YEARS) LAST BIRTHDAY 58 YRS. | | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD October 15, 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD | |
| 10. CITY OR TOWN OF DEATH Timonium | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2243 Greenspring Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Anodizer | | 12b. KIND OF BUSINESS OR INDUSTRY Chemicals | |
| 13a. STATE Maryland | | | | 13b. COUNTY A. A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 109 S. Meadow Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anton = Seymer | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carherine ? ? | | | | 16. SOCIAL SECURITY NO. 219-16-9128 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. (IF YES, GIVE WAR OR DATES) WW-2 | | 17. INFORMANT Christine Seymer | | | | ADDRESS same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4110 IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary Insufficiency (c) Generalized Atherosclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 2-7 yrs 2-5 yrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Wm. F. Connelley | | | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME Raymond C. Fink | | | | ADDRESS Glen Burnie, Md. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 18 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Canine | |

[Faint, illegible text, possibly bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|---|--|-----------------------------------|--|--|--|--|----------|
| 1. FOR STATE REGISTRAR | | 8 2 2 5 3 3 6 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR |
| CHARLES C. SHAFER | | | | | | | | 10 12 82 | | 7:01A M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| M | W | MONTH DAY YEAR 8 12 11 | | 71 YRS | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| MD | US | | | Baltimore County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Towson | Greater Balto Medical Center | | Broker | | Food | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | |
| Maryland | | Baltimore | | Towson | | | | 6624 Charlesway 21204 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FIRST MIDDLE LAST J. Frederick Shafer | | FIRST MIDDLE LAST Eunetta Classen | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | |
| No | | 215 05 3433 | | Mrs. Charles C. Shafer, | | Same | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Oat Cell Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-1</u> , 19 <u>82</u> , to <u>10-12</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>10/12</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | | |
| Robert A. Palermo | | | | | | 10/12/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | |
| Robert A. Palermo, M.D. | | 6701 N. Charles St, Balto. Md 21204 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Cremation | | 10/13/82 | | Green Mount | | Balto. MD | | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | OCT 14 1982 | | John J. [Signature] | | | | | | |



Mr. J. F. ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 3 7
REG. NO.

| | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) ANNIE L. SHAW | | | 2a DATE OF DEATH MONTH DAY YEAR October 13, 1982 | | | 2b HOUR 9:30A_M | | | | |
| 3 SEX Female | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR June 17, 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS 79 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | | | | |
| 10 CITY OR TOWN OF DEATH Pikesville | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6710 Chisholm Drive | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper-Ret. | | 12b KIND OF BUSINESS OR INDUSTRY Clothing Manu | | |
| 13a STATE Maryland | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Pikesville | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 6710 Chisholm Drive | |
| 14 FATHER'S NAME FIRST MIDDLE LAST George Washington Lloyd | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Green | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17 INFORMANT ADDRESS Edward M. Shaw, 6710 Chisholm Drive | | | | | |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 3940 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) R.H.D. cardiac stenosis (c) Myocardial Stenosis & Insufficiency. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 20 yrs. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-12-1982 to 10-10-1982 , that (I) (we) last saw the deceased alive on 6-12-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Lawrence Solomon | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10 15 82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE SOLOMON | | | | | 22e. ADDRESS 600 ROSTERTOWN RD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Baltimore Co., Md | | | |
| 24. FUNERAL DIRECTOR NAME Frank J. Dell'Acqua | | | | | WOODLAWN MEMORIAL FH 6411 Windsor Mill Rd | | 25a. DATE REC'D. BY REGISTRAR OCT 22 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conish | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 3 8 | |
|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) BLANCHE SHEAR | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 4 82 2130 PM | | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 8 14 99 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | 13c. CITY OR TOWN RANDALLSTOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DAVID PIVARNICK | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HINDA UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-12-0774 | | 17. INFORMANT DONALD D. SHEAR 8418 CHARLTON RD. RANDALLSTOWN, MD 21133 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Gas intestinal bleeding</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Hafeez A Syed | | DEGREE | | 22c. DATE SIGNED 10/4/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFAEEZ A SYED M.D. | | 22e. ADDRESS BALTIMORE COUNTY GEN HOSP | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE OCT. 6, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY ANSHE EMONAH | |
| 23d. LOCATION BALTIMORE | | COUNTY MARYLAND | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 13 1982 | |
| | | | | REGISTRAR'S SIGNATURE John J. Conner | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 5 3 3 9 | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Horace T. Sheppard | | | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR 10 12 82 0150A.M. | | | | |
| 3. SEX M | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 5 23 99 | | 6. AGE (IN YEARS LAST BIRTHDAY) 18 83 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired owner taxicab co. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Ellicott City | | 13e. STREET ADDRESS 3224 N St. Johns Lane | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST late John | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Mary E. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr Earl Sheppard Chesapeake Court Box 152 Hanover Md 21076 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CARCINOMA OF LARYNX WITH METASTASES | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Harvey A Syed M.D. | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 10/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFFET A SYED M.D. | | | | | 22e. ADDRESS BALTIMORE COUNTY GEN HOSP. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL RECEIVED Burial | | 23b. DATE Oct 14, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY St Johns | | 23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City, Howard, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke 4112 Columbia Rd Ellicott City | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 13 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 4 0 | | | |
|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| EDWARD SHIPLEY | | | | October 18, 1982 | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE | |
| Male | | White | | MONTH DAY YEAR | | 77 YRS. | |
| 7a BIRTHPLACE | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore County MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a USUAL OCCUPATION | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Rossville 21237 | | Franklin Square Hospital | | Janitor | | Baltimore County | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | | |
| Md. | | | | Baltimore | | | |
| 13c. STREET ADDRESS | | | | 13d. INSIDE CITY LIMITS? | | | |
| 21220 | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | | FIRST LAST | | | |
| Unknown | | | | Unknown | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | |
| (YES, NO OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | Same | | (Wife) | |
| No | | 214 16 5651 | | Rose B. Shipley | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: Metastatic Carcinoma | | | | | | | |
| IMMEDIATE CAUSE (a) 1991 | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | |
| Chronic Emphysema | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 5, 19 82, to October 18, 19 82, that (I) (we) last saw the deceased alive on October 18, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Marc M. Levinson | | | | M.D. | | 10/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Marc M. Levinson | | | | 9000 Franklin Square Drive 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 10/21/82 | | Bel Air Memorial Garden | | Bel Air Harford, Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. | | | | OCT 20 1982 | | John J. Connel | |

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| Case No. | Case Name | Case Address | Case City | Case State | Case Zip | Case Date | Case Status |
|----------|-----------------|------------------|-----------|------------|----------|-----------|-------------|
| 1000 | John Doe | 123 Main St | Anytown | CA | 90001 | 10/1/73 | Open |
| 1001 | Jane Smith | 456 Elm St | Anytown | CA | 90001 | 10/2/73 | Open |
| 1002 | Bob Johnson | 789 Oak St | Anytown | CA | 90001 | 10/3/73 | Open |
| 1003 | Alice Brown | 101 Pine St | Anytown | CA | 90001 | 10/4/73 | Open |
| 1004 | Charlie White | 202 Birch St | Anytown | CA | 90001 | 10/5/73 | Open |
| 1005 | Diana Green | 303 Cedar St | Anytown | CA | 90001 | 10/6/73 | Open |
| 1006 | Frank Black | 404 Maple St | Anytown | CA | 90001 | 10/7/73 | Open |
| 1007 | Grace Hall | 505 Spruce St | Anytown | CA | 90001 | 10/8/73 | Open |
| 1008 | Henry King | 606 Willow St | Anytown | CA | 90001 | 10/9/73 | Open |
| 1009 | Ivy Lee | 707 Ash St | Anytown | CA | 90001 | 10/10/73 | Open |
| 1010 | Jack Miller | 808 Hickory St | Anytown | CA | 90001 | 10/11/73 | Open |
| 1011 | Karen Wilson | 909 Sycamore St | Anytown | CA | 90001 | 10/12/73 | Open |
| 1012 | Larry Young | 1010 Walnut St | Anytown | CA | 90001 | 10/13/73 | Open |
| 1013 | Mary Taylor | 1011 Chestnut St | Anytown | CA | 90001 | 10/14/73 | Open |
| 1014 | Ned Anderson | 1012 Elm St | Anytown | CA | 90001 | 10/15/73 | Open |
| 1015 | Olivia Baker | 1013 Oak St | Anytown | CA | 90001 | 10/16/73 | Open |
| 1016 | Peter Clark | 1014 Pine St | Anytown | CA | 90001 | 10/17/73 | Open |
| 1017 | Quinn Evans | 1015 Birch St | Anytown | CA | 90001 | 10/18/73 | Open |
| 1018 | Rachel Fisher | 1016 Cedar St | Anytown | CA | 90001 | 10/19/73 | Open |
| 1019 | Samuel Grant | 1017 Maple St | Anytown | CA | 90001 | 10/20/73 | Open |
| 1020 | Tina Harris | 1018 Spruce St | Anytown | CA | 90001 | 10/21/73 | Open |
| 1021 | Victor King | 1019 Willow St | Anytown | CA | 90001 | 10/22/73 | Open |
| 1022 | Wendy Lee | 1020 Ash St | Anytown | CA | 90001 | 10/23/73 | Open |
| 1023 | Xavier Miller | 1021 Hickory St | Anytown | CA | 90001 | 10/24/73 | Open |
| 1024 | Yvonne Wilson | 1022 Sycamore St | Anytown | CA | 90001 | 10/25/73 | Open |
| 1025 | Zoe Young | 1023 Walnut St | Anytown | CA | 90001 | 10/26/73 | Open |
| 1026 | Adam Taylor | 1024 Chestnut St | Anytown | CA | 90001 | 10/27/73 | Open |
| 1027 | Bella Anderson | 1025 Elm St | Anytown | CA | 90001 | 10/28/73 | Open |
| 1028 | Carl Baker | 1026 Oak St | Anytown | CA | 90001 | 10/29/73 | Open |
| 1029 | Dora Clark | 1027 Pine St | Anytown | CA | 90001 | 10/30/73 | Open |
| 1030 | Eugene Evans | 1028 Birch St | Anytown | CA | 90001 | 10/31/73 | Open |
| 1031 | Fiona Fisher | 1029 Cedar St | Anytown | CA | 90001 | 11/1/73 | Open |
| 1032 | Gordon Grant | 1030 Maple St | Anytown | CA | 90001 | 11/2/73 | Open |
| 1033 | Helen Harris | 1031 Spruce St | Anytown | CA | 90001 | 11/3/73 | Open |
| 1034 | Ian King | 1032 Willow St | Anytown | CA | 90001 | 11/4/73 | Open |
| 1035 | Jane Lee | 1033 Ash St | Anytown | CA | 90001 | 11/5/73 | Open |
| 1036 | Kyle Miller | 1034 Hickory St | Anytown | CA | 90001 | 11/6/73 | Open |
| 1037 | Laura Wilson | 1035 Sycamore St | Anytown | CA | 90001 | 11/7/73 | Open |
| 1038 | Mark Young | 1036 Walnut St | Anytown | CA | 90001 | 11/8/73 | Open |
| 1039 | Nancy Taylor | 1037 Chestnut St | Anytown | CA | 90001 | 11/9/73 | Open |
| 1040 | Oscar Anderson | 1038 Elm St | Anytown | CA | 90001 | 11/10/73 | Open |
| 1041 | Pamela Baker | 1039 Oak St | Anytown | CA | 90001 | 11/11/73 | Open |
| 1042 | Quinn Clark | 1040 Pine St | Anytown | CA | 90001 | 11/12/73 | Open |
| 1043 | Rachel Evans | 1041 Birch St | Anytown | CA | 90001 | 11/13/73 | Open |
| 1044 | Samuel Fisher | 1042 Cedar St | Anytown | CA | 90001 | 11/14/73 | Open |
| 1045 | Tina Grant | 1043 Maple St | Anytown | CA | 90001 | 11/15/73 | Open |
| 1046 | Victor Harris | 1044 Spruce St | Anytown | CA | 90001 | 11/16/73 | Open |
| 1047 | Wendy King | 1045 Willow St | Anytown | CA | 90001 | 11/17/73 | Open |
| 1048 | Xavier Lee | 1046 Ash St | Anytown | CA | 90001 | 11/18/73 | Open |
| 1049 | Yvonne Miller | 1047 Hickory St | Anytown | CA | 90001 | 11/19/73 | Open |
| 1050 | Zoe Wilson | 1048 Sycamore St | Anytown | CA | 90001 | 11/20/73 | Open |
| 1051 | Adam Young | 1049 Walnut St | Anytown | CA | 90001 | 11/21/73 | Open |
| 1052 | Bella Taylor | 1050 Chestnut St | Anytown | CA | 90001 | 11/22/73 | Open |
| 1053 | Carl Anderson | 1051 Elm St | Anytown | CA | 90001 | 11/23/73 | Open |
| 1054 | Dora Baker | 1052 Oak St | Anytown | CA | 90001 | 11/24/73 | Open |
| 1055 | Eugene Clark | 1053 Pine St | Anytown | CA | 90001 | 11/25/73 | Open |
| 1056 | Fiona Evans | 1054 Birch St | Anytown | CA | 90001 | 11/26/73 | Open |
| 1057 | Gordon Fisher | 1055 Cedar St | Anytown | CA | 90001 | 11/27/73 | Open |
| 1058 | Helen Grant | 1056 Maple St | Anytown | CA | 90001 | 11/28/73 | Open |
| 1059 | Ian Harris | 1057 Spruce St | Anytown | CA | 90001 | 11/29/73 | Open |
| 1060 | Jane King | 1058 Willow St | Anytown | CA | 90001 | 11/30/73 | Open |
| 1061 | Kyle Lee | 1059 Ash St | Anytown | CA | 90001 | 12/1/73 | Open |
| 1062 | Laura Miller | 1060 Hickory St | Anytown | CA | 90001 | 12/2/73 | Open |
| 1063 | Mark Wilson | 1061 Sycamore St | Anytown | CA | 90001 | 12/3/73 | Open |
| 1064 | Nancy Young | 1062 Walnut St | Anytown | CA | 90001 | 12/4/73 | Open |
| 1065 | Oscar Taylor | 1063 Chestnut St | Anytown | CA | 90001 | 12/5/73 | Open |
| 1066 | Pamela Anderson | 1064 Elm St | Anytown | CA | 90001 | 12/6/73 | Open |
| 1067 | Quinn Baker | 1065 Oak St | Anytown | CA | 90001 | 12/7/73 | Open |
| 1068 | Rachel Clark | 1066 Pine St | Anytown | CA | 90001 | 12/8/73 | Open |
| 1069 | Samuel Evans | 1067 Birch St | Anytown | CA | 90001 | 12/9/73 | Open |
| 1070 | Tina Fisher | 1068 Cedar St | Anytown | CA | 90001 | 12/10/73 | Open |
| 1071 | Victor Grant | 1069 Maple St | Anytown | CA | 90001 | 12/11/73 | Open |
| 1072 | Wendy Harris | 1070 Spruce St | Anytown | CA | 90001 | 12/12/73 | Open |
| 1073 | Xavier King | 1071 Willow St | Anytown | CA | 90001 | 12/13/73 | Open |
| 1074 | Yvonne Lee | 1072 Ash St | Anytown | CA | 90001 | 12/14/73 | Open |
| 1075 | Zoe Miller | 1073 Hickory St | Anytown | CA | 90001 | 12/15/73 | Open |
| 1076 | Adam Wilson | 1074 Sycamore St | Anytown | CA | 90001 | 12/16/73 | Open |
| 1077 | Bella Young | 1075 Walnut St | Anytown | CA | 90001 | 12/17/73 | Open |
| 1078 | Carl Taylor | 1076 Chestnut St | Anytown | CA | 90001 | 12/18/73 | Open |
| 1079 | Dora Anderson | 1077 Elm St | Anytown | CA | 90001 | 12/19/73 | Open |
| 1080 | Eugene Baker | 1078 Oak St | Anytown | CA | 90001 | 12/20/73 | Open |
| 1081 | Fiona Clark | 1079 Pine St | Anytown | CA | 90001 | 12/21/73 | Open |
| 1082 | Gordon Evans | 1080 Birch St | Anytown | CA | 90001 | 12/22/73 | Open |
| 1083 | Helen Fisher | 1081 Cedar St | Anytown | CA | 90001 | 12/23/73 | Open |
| 1084 | Ian Grant | 1082 Maple St | Anytown | CA | 90001 | 12/24/73 | Open |
| 1085 | Jane Harris | 1083 Spruce St | Anytown | CA | 90001 | 12/25/73 | Open |
| 1086 | Kyle King | 1084 Willow St | Anytown | CA | 90001 | 12/26/73 | Open |
| 1087 | Laura Lee | 1085 Ash St | Anytown | CA | 90001 | 12/27/73 | Open |
| 1088 | Mark Miller | 1086 Hickory St | Anytown | CA | 90001 | 12/28/73 | Open |
| 1089 | Nancy Wilson | 1087 Sycamore St | Anytown | CA | 90001 | 12/29/73 | Open |
| 1090 | Oscar Young | 1088 Walnut St | Anytown | CA | 90001 | 12/30/73 | Open |
| 1091 | Pamela Taylor | 1089 Chestnut St | Anytown | CA | 90001 | 12/31/73 | Open |
| 1092 | Quinn Anderson | 1090 Elm St | Anytown | CA | 90001 | 1/1/74 | Open |
| 1093 | Rachel Baker | 1091 Oak St | Anytown | CA | 90001 | 1/2/74 | Open |
| 1094 | Samuel Clark | 1092 Pine St | Anytown | CA | 90001 | 1/3/74 | Open |
| 1095 | Tina Evans | 1093 Birch St | Anytown | CA | 90001 | 1/4/74 | Open |
| 1096 | Victor Fisher | 1094 Cedar St | Anytown | CA | 90001 | 1/5/74 | Open |
| 1097 | Wendy Grant | 1095 Maple St | Anytown | CA | 90001 | 1/6/74 | Open |
| 1098 | Xavier Harris | 1096 Spruce St | Anytown | CA | 90001 | 1/7/74 | Open |
| 1099 | Yvonne King | 1097 Willow St | Anytown | CA | 90001 | 1/8/74 | Open |
| 1100 | Zoe Lee | 1098 Ash St | Anytown | CA | 90001 | 1/9/74 | Open |
| 1101 | Adam Miller | 1099 Hickory St | Anytown | CA | 90001 | 1/10/74 | Open |
| 1102 | Bella Wilson | 1100 Sycamore St | Anytown | CA | 90001 | 1/11/74 | Open |
| 1103 | Carl Young | 1101 Walnut St | Anytown | CA | 90001 | 1/12/74 | Open |
| 1104 | Dora Taylor | 1102 Chestnut St | Anytown | CA | 90001 | 1/13/74 | Open |
| 1105 | Eugene Anderson | 1103 Elm St | Anytown | CA | 90001 | 1/14/74 | Open |
| 1106 | Fiona Baker | 1104 Oak St | Anytown | CA | 90001 | 1/15/74 | Open |
| 1107 | Gordon Clark | 1105 Pine St | Anytown | CA | 90001 | 1/16/74 | Open |
| 1108 | Helen Evans | 1106 Birch St | Anytown | CA | 90001 | 1/17/74 | Open |
| 1109 | Ian Fisher | 1107 Cedar St | Anytown | CA | 90001 | 1/18/74 | Open |
| 1110 | Jane Grant | 1108 Maple St | Anytown | CA | 90001 | 1/19/74 | Open |
| 1111 | Kyle Harris | 1109 Spruce St | Anytown | CA | 90001 | 1/20/74 | Open |
| 1112 | Laura King | 1110 Willow St | Anytown | CA | 90001 | 1/21/74 | Open |
| 1113 | Mark Lee | 1111 Ash St | Anytown | CA | 90001 | 1/22/74 | Open |
| 1114 | Nancy Miller | 1112 Hickory St | Anytown | CA | 90001 | 1/23/74 | Open |
| 1115 | Oscar Wilson | 1113 Sycamore St | Anytown | CA | 90001 | 1/24/74 | Open |
| 1116 | Pamela Young | 1114 Walnut St | Anytown | CA | 90001 | 1/25/74 | Open |
| 1117 | Quinn Taylor | 1115 Chestnut St | Anytown | CA | 90001 | 1/26/74 | Open |
| 1118 | Rachel Anderson | 1116 Elm St | Anytown | CA | 90001 | 1/27/74 | Open |
| 1119 | Samuel Baker | 1117 Oak St | Anytown | CA | 90001 | 1/28/74 | Open |
| 1120 | Tina Clark | 1118 Pine St | Anytown | CA | 90001 | 1/29/74 | Open |
| 1121 | Victor Evans | 1119 Birch St | Anytown | CA | 90001 | 1/30/74 | Open |
| 1122 | Wendy Fisher | 1120 Cedar St | Anytown | CA | 90001 | 1/31/74 | Open |
| 1123 | Xavier Grant | 1121 Maple St | Anytown | CA | 90001 | 2/1/74 | Open |
| 1124 | Yvonne Harris | 1122 Spruce St | Anytown | CA | 90001 | 2/2/74 | Open |
| 1125 | Zoe King | 1123 Willow St | Anytown | CA | 90001 | 2/3/74 | Open |
| 1126 | Adam Lee | 1124 Ash St | Anytown | CA | 90001 | 2/4/74 | Open |
| 1127 | Bella Miller | 1125 Hickory St | Anytown | CA | 90001 | 2/5/74 | Open |
| 1128 | Carl Wilson | 1126 Sycamore St | Anytown | CA | 90001 | 2/6/74 | Open |
| 1129 | Dora Young | 1127 Walnut St | Anytown | CA | 90001 | 2/7/74 | Open |
| 1130 | Eugene Taylor | 1128 Chestnut St | Anytown | CA | 90001 | 2/8/74 | Open |
| 1131 | Fiona Anderson | 1129 Elm St | Anytown | CA | 90001 | 2/9/74 | Open |
| 1132 | Gordon Baker | 1130 Oak St | Anytown | CA | 90001 | 2/10/74 | Open |
| 1133 | Helen Clark | 1131 Pine St | Anytown | CA | 90001 | 2/11/74 | Open |
| 1134 | Ian Evans | 1132 Birch St | Anytown | CA | 90001 | 2/12/74 | Open |
| 1135 | Jane Fisher | 1133 Cedar St | Anytown | CA | 90001 | 2/13/74 | Open |
| 1136 | Kyle Grant | 1134 Maple St | Anytown | CA | 90001 | 2/14/74 | Open |
| 1137 | Laura Harris | 1135 Spruce St | Anytown | CA | 90001 | 2/15/74 | Open |
| 1138 | Mark King | 1136 Willow St | Anytown | CA | 90001 | 2/16/74 | Open |
| 1139 | Nancy Lee | 1137 Ash St | Anytown | CA | 90001 | 2/17/74 | Open |
| 1140 | Oscar Miller | 1138 Hickory St | Anytown | CA | 90001 | 2/18/74 | Open |
| 1141 | Pamela Wilson | 1139 Sycamore St | Anytown | CA | 90001 | 2/19/74 | Open |
| 1142 | Quinn Young | 1140 Walnut St | Anytown | CA | 90001 | 2/20/74 | Open |
| 1143 | Rachel Taylor | 1141 Chestnut St | Anytown | CA | 90001 | 2/21/74 | Open |
| 1144 | Samuel Anderson | 1142 Elm St | Anytown | CA | 90001 | 2/22/74 | Open |
| 1145 | Tina Baker | 1143 Oak St | Anytown | CA | 90001 | 2/23/74 | Open |
| 1146 | Victor Clark | 1144 Pine St | Anytown | CA | 90001 | 2/24/74 | Open |
| 1147 | Wendy Evans | 1145 Birch St | Anytown | CA | 90001 | 2/25/74 | Open |
| 1148 | Xavier Fisher | 1146 Cedar St | Anytown | CA | 90001 | 2/26/74 | Open |
| 1149 | Yvonne Grant | 1147 Maple St | Anytown | CA | 90001 | 2/27/74 | Open |
| 1150 | Zoe Harris | 1148 Spruce St | Anytown | CA | 90001 | 2/28/74 | Open |
| 1151 | Adam King | 1149 Willow St | Anytown | CA | 90001 | 2/29/74 | Open |
| 1152 | Bella Lee | 1150 Ash St | Anytown | CA | 90001 | 2/30/74 | Open |
| 1153 | Carl Miller | 1151 Hickory St | Anytown | CA | 90001 | 3/1/74 | Open |
| 1154 | Dora Wilson | 1152 Sycamore St | Anytown | CA | 90001 | 3/2/74 | Open |
| 1155 | Eugene Young | 1153 Walnut St | Anytown | CA | 90001 | 3/3/74 | Open |
| 1156 | Fiona Taylor | 1154 Chestnut St | Anytown | CA | 90001 | 3/4/74 | Open |
| 1157 | Gordon Anderson | 1155 Elm St | Anytown | CA | 90001 | 3/5/74 | Open |
| 1158 | Helen Baker | 1156 Oak St | Anytown | CA | 90001 | 3/6/74 | Open |
| 1159 | Ian Clark | 1157 Pine St | Anytown | CA | 90001 | 3/7/74 | Open |
| 1160 | Jane Evans | 1158 Birch St | Anytown | CA | 90001 | 3/8/74 | Open |
| 1161 | Kyle Fisher | 1159 Cedar St | Anytown | CA | 90001 | 3/9/74 | Open |
| 1162 | Laura Grant | 1160 Maple St | Anytown | CA | 90001 | 3/10/74 | Open |
| 1163 | Mark Harris | 1161 Spruce St | Anytown | CA | 90001 | 3/11/74 | Open |
| 1164 | Nancy King | 1162 Willow St | Anytown | CA | 90001 | 3/12/74 | Open |
| 1165 | Oscar Lee | 1163 Ash St | Anytown | CA | 90001 | 3/13/74 | Open |
| 1166 | Pamela Miller | 1164 Hickory St | Anytown | CA | 90001 | 3/14/74 | Open |
| 1167 | Quinn Wilson | 1165 Sycamore St | Anytown | CA | 90001 | 3/15/74 | Open |
| 1168 | R | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|---------------|
| 8 2 2 5 3 4 1 | | | | | | | | | | |
| 1- FOR STATE REGISTRAR | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion Chester Shipley | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Oct. 4 1982 | | | | | 2b. HOUR M |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH MONTH DAY YEAR Mar. 29, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County | | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2218 Rockhaven Ave. (21228) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Grocery | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2218 Rockhaven Ave. (21228) | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert Shipley | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cary Hepting | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 217 01 3996 | | 17. INFORMANT Gladys Shipley Catonsville, Maryland 21228 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SMALL CELL C.A. OF LUNG 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 44 | | | | | | |
| 22a. I certify that I (the hospital) attended the deceased from NOVEMBER 3 19 82 to OCTOBER 4 19 82 , that I (we) last saw the deceased alive on SEPTEMBER 13 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death) | | | | | | | | | | |
| 22b. SIGNATURE Diana H. Griffiths | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 10/6/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DIANA H. GRIFFITHS | | | | 22e. ADDRESS 900 ST. AGNES HOSPITAL CATON AVE. BALT, MD. 21229 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 10/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Ellicott City, Howard, Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 6 1982 | | | | | | |
| 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

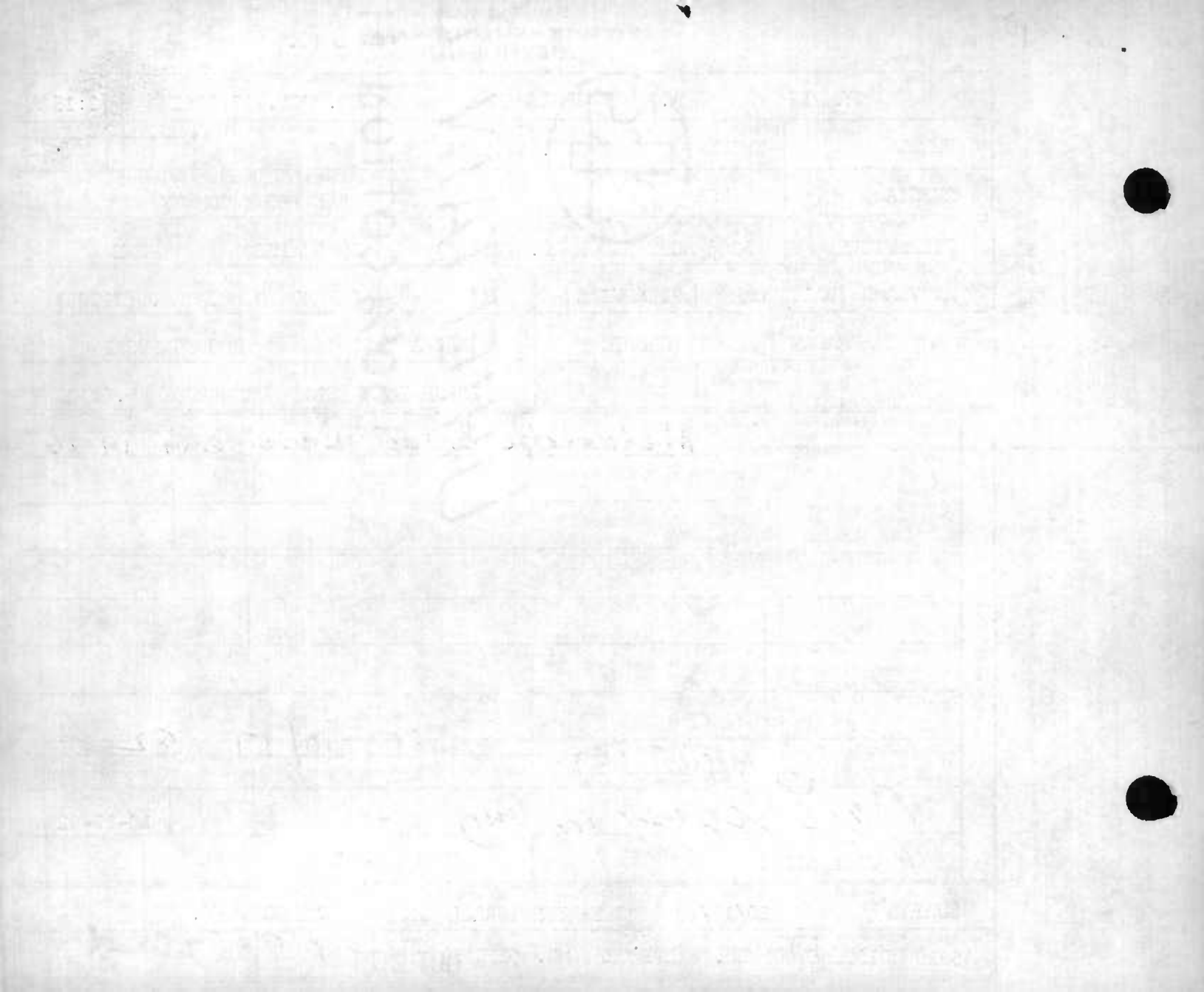
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|-------------------------|--|--|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FANNIE A. SHNIDMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR SUN. OCT. 17, 1982 | | 2b. HOUR 2:15 AM | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 19, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH PIKESVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3208 NORTHBROOK RD. (21208) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN PIKESVILLE | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RABBI ABRAHAM RESNICK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BAILA ROGOSCHEVSKI | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. NO | | 17. INFORMANT ADDRESS LOUIS SHNIDMAN 3208 NORTHBROOK RD. (21208) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 1982 to 10/17/82 that (I) (we) last saw the deceased alive above , (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Jack Nissim DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 10-17-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK NISSIM | | | | 22e. ADDRESS SINAI HOSPITAL | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 10/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY SHEARITH ISRAEL CEM | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | |
| 25a. DATE REC'D. BY REGISTRAR OCT 20 1982 | | | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 4 3 | | | |
|--|--|---|--|--|--|---|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MARY L. SHOEMAKER | | | | 2a. DATE OF DEATH (MONTH DAY YEAR) OCTOBER 4, 1982 | | 4. HOUR P 4:25 PM | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH (MONTH DAY YEAR) 06 15 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON (TOWSON) | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN ROSEDALE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME DAVID W. REDFORD | | 15. MOTHER'S MAIDEN NAME CARRIE | | 13e. STREET ADDRESS 1279 NEIGHBORS AVE. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213186898 | | 17. INFORMANT ADDRESS LAWRENCE BUTTION 1008 CHESACO AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY: 5934 IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CHRONIC MYOCARDIAL (c) HYPERTENSION | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: CHRONIC CORONARY FAILURE / ABCVD | | | | | | | |
| 19a. DATE OF OPERATION 9/27/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right UPT OBSTRUCTION | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/15 , 19 82 , to 10/4 , 19 82 , that X (we) lost saw the deceased alive on 10/04 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE [Signature] | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD S. STOVORE | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (USE PREFIX) BURIAL | | 23b. DATE 10/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO BALTO MD. | |
| 24. FUNERAL DIRECTOR [Signature] | | ADDRESS 1211 Chesaco Ave | | 25a. DATE REC'D. BY REGISTRAR OCT 5 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GERTRUDE L. SHORT | | | 2a. DATE OF DEATH MONTH 10 DAY 30 YEAR 82 | | | 2b. HOUR 0455A | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 7 DAY 21 YEAR 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Woodlawn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 1904 Calais Ct | | 21207 | | | | | |
| 14. FATHER'S NAME FIRST William MIDDLE Lourey LAST Lowrey | | | | 15. MOTHER'S MAIDEN NAME FIRST Mildred MIDDLE (Unknown) LAST (Unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-18-0459 | | 17. INFORMANT ADDRESS Russell H. Short Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Cerebrovascular accident IMMEDIATE CAUSE (a) 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Aspiration pneumonia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I (this hospital) attended the deceased from 10-2 19 82 , to 10-30 19 82 , that (we) last saw the deceased alive on 10/28 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Dr. Narayan | | | | DEGREE V. NARAYEN | | 22c. DATE SIGNED 10/30/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. NARAYEN | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery | | 23d. LOCATION CITY OR TOWN Marriottsville COUNTY Howard STATE Md | |
| 24. FUNERAL DIRECTOR NAME Witzke, P.A. ADDRESS 1630 Edmondson Ave Catonsville, Md. 21228 | | | | 25. DATE REG'D. BY REGISTRAR NOV 1 1982 25b. REGISTRAR'S SIGNATURE | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 4 5 | | | |
|--|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST HERBERT J. SIMS, SR. | | | | MONTH DAY YEAR October 7, 1982 | | 10:45Am | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | MONTH DAY YEAR May 2, 1894 | | 88 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Baltimore County, MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 21234 | | 8711 Lackawanna Avenue | | Carpenter | | Carpentry | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Baltimore | | 21234 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | 21234 | |
| FIRST MIDDLE LAST Charles H. Sims | | FIRST MIDDLE LAST Lydia Brown | | 8711 Lackawanna Avenue | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| Yes | | W.W. I | | 212-09-8100 | | Herbert J. Sims, Jr. 21093 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | Sudden | | | |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Emphysema.</u> | | | | 10 years. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) the physician attended the deceased from <u>March 1964</u> to <u>Present</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>March 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>Keith A. Manley</u> | | | | | | 10-8-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Keith A. Manley, M.D. | | 1818 Pots Spring Road | | 252-1303 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | Oct. 9, '82 | | Moreland Mem. Park | | Baltimore County, MD | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25. DATE REC'D. BY REGISTRAR (REGISTRAR'S SIGNATURE) | | | |
| William E. Johnson | | 8521 Loch Raven Blvd. | | OCT 8 1982 <u>John J. [Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 35 should be filled in.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 5 3 4 6 REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| FIRST MIDDLE LAST <i>Richard Emmons Skinner</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>10 17 82</i> | | | |
| 3. SEX <i>MALE</i> | | | | 7b. HOUR <i>4⁵² AM</i> | | | |
| 4. RACE <i>WHITE</i> | | | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 15, 1900</i> | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> | | | | 8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Rossville</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MANOR CARE ROSSVILLE</i> | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Tug Boat Oper.</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Const.</i> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY <i>Maryland Charles</i> | | | | 13c. CITY OR TOWN <i>Newburg</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John E. Skinner</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nettie Adams</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes Peacetime</i> | | | | 16b. SOCIAL SECURITY NO. <i>220-28-6749</i> | | | |
| 17. INFORMANT (Son) <i>Richard G. Skinner</i> | | | | ADDRESS <i>9232 Ravenwood Road Baltimore, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Alzheimer's disease</i> <i>3310</i> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>yr.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Depression, A.S.C.V.D.</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <i>AT</i> (this hospital) attended the deceased from <i>8/11/82</i> to <i>10/17/82</i> , that <i>he</i> (we) lost saw the deceased alive on <i>4:30pm 10/17/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <i>that</i> (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>W. J. Tun</i> | | | | DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>10/17/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>K. M. TUN</i> | | | | 22e. ADDRESS <i>2110 Pot Spring Road md 21093</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>10-19-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Trinity Mem. Gardens</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Waldorf, Charles, Md.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Hunt Funeral Home, Waldorf, Maryland</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>OCT 19 1982</i> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i> | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 4 7

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Estel A. Slider | | 2a. DATE OF DEATH MONTH DAY YEAR October 13, 1982 | | 2b. HOUR 5:51 a.m. | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 12/25/13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH ROSSVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNK | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD. | | 13b. COUNTY BALTO. | 13c. CITY OR TOWN MIDDLE RIVER | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALONZO SLIDER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIOLA DAVIS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNK | | 16b. SOCIAL SECURITY NO. 705 10 7213 | | 17. INFORMANT ADDRESS HILDA SLIDER ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIOGENIC Shock 4920 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Emphysema DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/13 , 19 82 to 10/13 , 19 82 , that (I) (we) last saw the deceased alive on 10/13 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Alexander P. CADOUX | | 22c. DATE SIGNED 10/13/83 | | 22d. ADDRESS Franklin Square Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | 24. FUNERAL DIRECTOR NAME ADDRESS Connelly F.H. 300 More ave. | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

MEDICAL CERTIFICATION

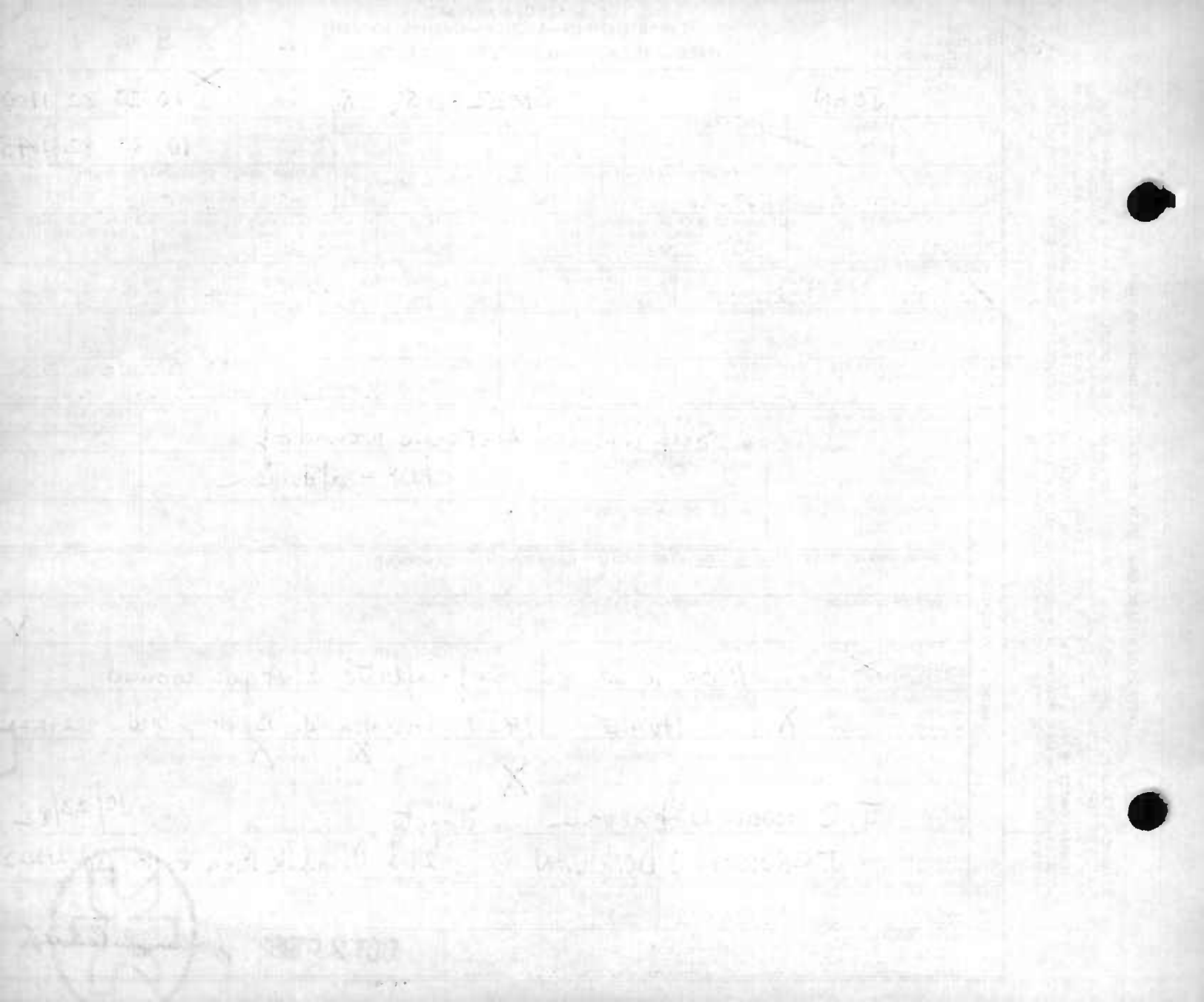
2
9

BP _____
DHMH - T7
(VR A15 ME (5)
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 5 3 4 8
REG. NO.

| | | | | | |
|--|---------|---|-------------------------------|--|---|
| 1- STATE REGISTRAR | | FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 2 5 3 4 8 | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE KNOWN OF DEATH | |
| JOHN | | SMELZGUS, SR. | | MONTH DAY YEAR 10 23 82 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 7. IF UNDER 24 HRS. |
| Male | White | MONTH DAY YEAR 3 21 1928 | LAST BIRTHDAY 54 YRS. | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Pennsylvania | | U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Dundalk | | 1927 Inverton Road | | Mechanic | |
| 13a. STATE | | 13b. CITY OR TOWN | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | | Baltimore | Dundalk | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1927 Inverton Road 21222 |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| FIRST MIDDLE LAST Anthony Smelgus | | | FIRST MIDDLE LAST Susan Kelec | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| Yes | | | WW II | | |
| 17. INFORMANT | | | 17b. ADDRESS | | |
| Emogene H. Smelgus--Balto., MD. | | | 1927 Inverton Road 21222 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Self inflicted shotgun wound of chest + abdomen | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR 1100 P.M. 10 23 82 | | Self-inflicted shot-gun wound | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | HOME | | 1927 Inverton Rd. Balto., Md. 21222 | |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| J. Crossan O'Donovan | | Deputy | | 10/23/82 | |
| EXAMINER'S NAME | | ADDRESS | | MEDICAL EXAMINER | |
| J. CROSSAN O'DONOVAN | | 2112 Dundalk Ave., Balto., Md. 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 10/26/82 | | Holly Hill | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE RECEIVED BY REGISTRAR | |
| Duda-Ruck, Inc. | | 7922 Wise Avenue Dundalk, MD. 21222 | | 10/26/82 | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | | |
| John J. Conely | | John J. Conely | | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 4 9

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELAINE SMITH | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 24 82 | | | 2b. HOUR M M | | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 3 17 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 9. CITIZEN OF WHAT COUNTRY? US | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7905 BROOKFORD CIRCLE 21208 | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DENTAL ASSISTANT | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE | | | 17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 18. STREET ADDRESS 7905 BROOKFORD CIRCLE 21208 | | | | | |
| 19. FATHER'S NAME (FIRST MIDDLE LAST) CALVIN WESLEY | | | 20. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) JENNIE MAE MITCHELL | | | | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 22. SOCIAL SECURITY NO. 216-28-9157 | | 23. INFORMANT ADDRESS MICHAEL SMITH 7905 BROOKFORD CIRCLE | | | | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial System failure</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis generalis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the Colon</u> | | | | | | | | | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>dehydration, intestinal fistula</u> | | | | | | | | | | |
| 26. DATE OF OPERATION 9/10/82 | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ringing lesion, colorectal</u> | | | | 28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA | | | | | | |
| 33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 35. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 36. I certify that (I) (this hospital) attended the deceased from <u>05/17/82</u> to <u>date of demise</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>10/14/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 37. SIGNATURE <u>Gerard M. Woel</u> | | | | 38. DEGREE | | 39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 40. DATE SIGNED 10/27/82 | | |
| 41. PHYSICIAN'S NAME (TYPE OR PRINT) GERARD M WOEL | | | | 42. ADDRESS 3502 West Republic Baltimore Md 21215 | | | | | | |
| 43. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 44. DATE 10-28-82 | | 45. NAME OF CEMETERY OR CREMATORY GARDEN OF ETERNAL HOPE | | 46. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | | |
| 47. FUNERAL DIRECTOR NAME 1721 N. MONROE ST. | | | | 48. ADDRESS | | 49. DATE REC'D. BY REGISTRAR OCT 28 1982 | | 50. REGISTRAR'S SIGNATURE <u>Joan J. Connel</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

44-7742-1002-11

OXFORD UNIVERSITY PRESS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FRANK A. SMITH | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Oct. 4, 1982 | | 2b. HOUR 8AM | |
| 3. SEX Male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 21, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL STREET ADDRESS) 104 Locust Dr. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Furn & Appl. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY Catonsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 104 Locust Dr. 21228 | |
| 14. FATHER'S NAME MIDDLE Charles LAST Smith | | | | 15. MOTHER'S MAIDEN NAME MIDDLE Bewley LAST Catonsville, Md. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none | | 17. INFORMANT ADDRESS Mrs. Kathleen W. Smith 104 Locust Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1990 IMMEDIATE CAUSE (a) Coronary Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) Signet Cell Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) 3 years | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR IV | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/3 19 82 , to 10/4 19 82 , that (I) (we) last saw the deceased alive on 10/3 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE James Nolan | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JJ NOLAN | | | | 22e. ADDRESS 1 Muller Hill Rd Balt Md 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE Oct. 6, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cent. Baltimore, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR Starling Funeral Estate 226 Edmondson Ave. - Catonsville, Md. 21228 | | | | 25. DATE REC'D. BY REGISTRAR OCT 5 1982 | | | | | |
| | | | | 26. REGISTRAR'S SIGNATURE John J. Lohr | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|------------------|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 10 | | 5 | | 1982 | | 7:35 P _M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| M | | Black | | MONTH DAY YEAR 6 28 30 | | 52 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| MARYLAND | | US | | | | Baltimore County MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Towson | | Greater Balto. Medical Center | | | | | | | | | | UNEMPLOYED | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| MARYLAND | | BALTIMORE | | COCKEYSVILLE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 328 SHERWOOD RD 21030 | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | | | | | |
| WILLIAM | | JOHNSON | | INEZ SMITH | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| NO | | ? ? | | MRS. NELLIE HILL | | 15115 FALLS RD. BUTLER, MD. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Enterococcal (Sub)acute Bacterial Endocarditis | | | | | | | | | | | | | | | |
| 4210 | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | STREET | | CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/27, 19 82, to 10/5, 19 82, that (I) (we) last saw the deceased alive on 10/5, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | |
| | | | | 10/6/82 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | |
| Rudiger Breiteneker, M.D. | | 6701 N. Charles St, Towson, Md. 21204 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | | | | | | | |
| BURIAL | | 10/9/82 | | PINEY GROVE CEMETERY | | BORING | | (BALTO.) MD. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| NAME ADDRESS | | OCT 11 1982 | | John J. [Signature] | | | | | | | | | | | |
| LEWIS T. GWYNN | | 4517 PARK HEIGHTS AVENUE | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

LEWIS T. GWINN 1517 EAST HIGHTS AVENUE

10/9/82

FINNEY GREAT CHURCH

BOILING

(BARTO.)

MR.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 5 2

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH E SMITH | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-26-82 | | 2b. HOUR 7:45a M |
| 3 SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 10, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Maryland | 13b. COUNTY Baltimore | 13c. CITY OR TOWN 21234 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 8665 Oak Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank B. Shatzner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L. Sando | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT ADDRESS 21234 Mildred M. Stagge 1306 Aintree Road | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4292

IMMEDIATE CAUSE (a)

CEREBROVASCULAR ACCIDENT DUE TO

DUE TO, OR AS A CONSEQUENCE OF

(b) ATRIAL FIBRILLATION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

MEDICAL CERTIFICATION

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/11, 1982, to 10/26, 1982, that (I) (we) lost saw the deceased alive on 10/25, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | |
| 22b. SIGNATURE Lester A. Wall Jr. MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 10/26/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LESTER A. WALL JR. | | 22e. ADDRESS 7620 York Rd Towson, Md. | |

| | | | |
|--|---------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Oct. 28, '82 | 23c. NAME OF CEMETERY OR CREMATORY Harbaugh's Church | 23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro, Pennsylvania |
| 24. FUNERAL DIRECTOR NAME William E. Johnson | | 25a. DATE REC'D. BY REGISTRAR OCT 27 1982 | 25b. REGISTRAR'S SIGNATURE John J. Lauer |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and a table on lined paper. The table has several columns and rows, with some text visible in the cells. The handwriting is cursive and somewhat faded.

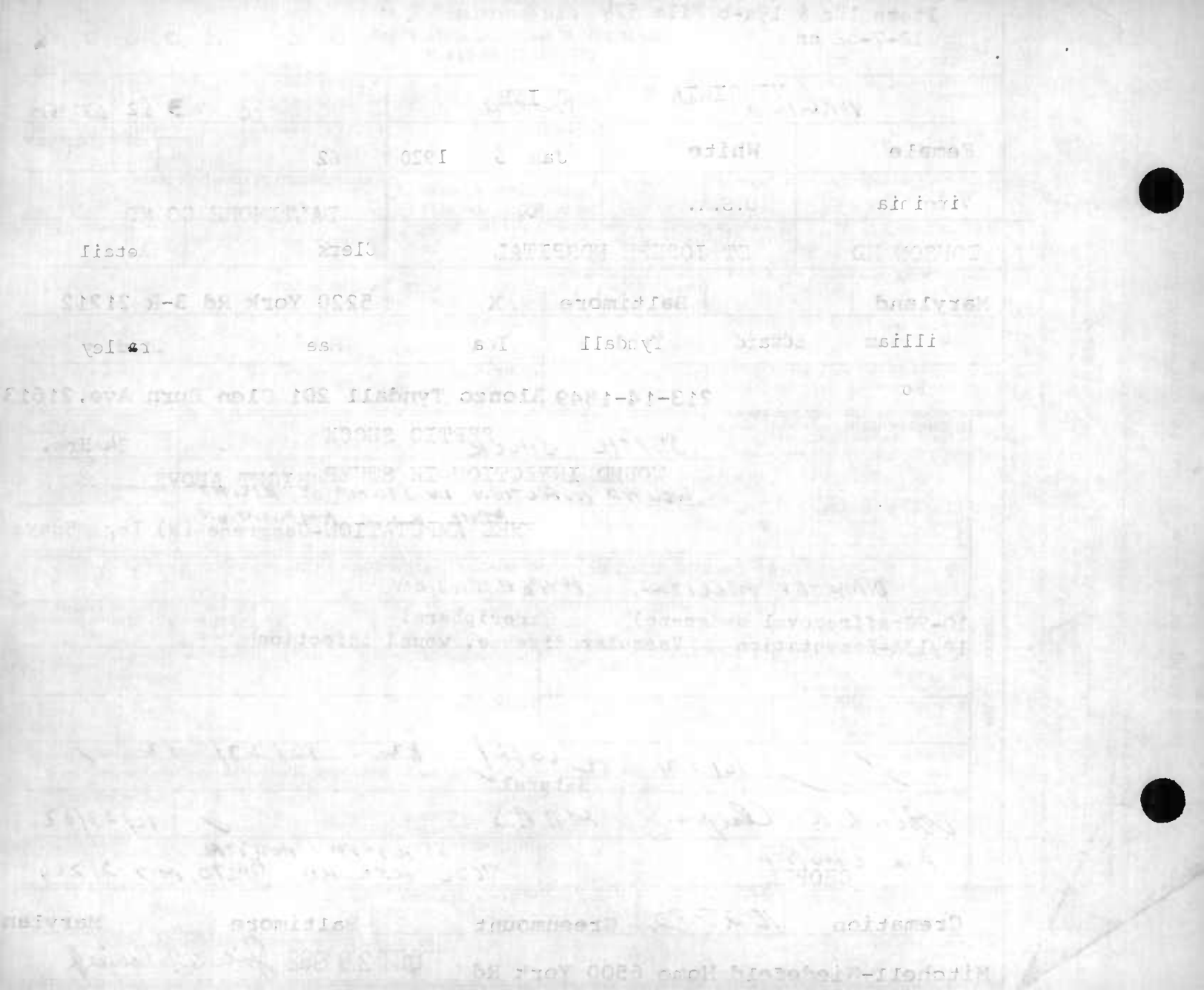
Handwritten notes and a table on lined paper. The table has several columns and rows, with some text visible in the cells. The handwriting is cursive and somewhat faded.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (item 18) must be notified at once.

| Items 18c & 19a-b Film 574 | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 2 5 3 5 3 | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 12-7-82 cn | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) VIRGINIA T. SMITH | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 23 82 | | 2b. HOUR 03:35 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan 5 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO MD MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Retail | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME William Edward Tyndall | | 15. MOTHER'S MAIDEN NAME Ida Mae Bradley | | 13e. STREET ADDRESS 5220 York Rd 3-R 21212 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-14-1849 | | 17. INFORMANT Alonzo Tyndall | | ADDRESS 201 Glen Burn Ave. 21613 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4439 SEPTIC SHOCK | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. | | | |
| IMMEDIATE CAUSE (a) WOUND INFECTION IN STUMP RIGHT ABOVE | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) WOUND INFECTION IN STUMP OF RIGHT | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) KNEE AMPUTATION-Gangrene (R) Leg | | | | | | 5days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS, HYPERTENSION. | | | | | | | |
| 19a. DATE OF OPERATION 10-7 Graffire removal (gangrene) | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Peripheral Vascular disease, wound infection | | 20a. AUTOPSY? YES | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. INJURY OCCURRED WHILE AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (if (this hospital) attended the deceased I saw the deceased alive on 10/23/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if (we) (did) (did not) view the body after death, Natural | | | | 22b. SIGNATURE A.K. CHOPRA | | 22c. DATE SIGNED 10/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.K. CHOPRA | | | | 22e. ADDRESS ST JOSEPH HOSPITAL, 7620 YORK RD, BALTO, MD 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 10-25-82 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home | | | | 24b. ADDRESS 6500 York Rd | | 25a. DATE REC'D. BY REGISTRAR OCT 29 1982 | |
| | | | | REGISTRAR'S SIGNATURE John J. Carver | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William M. SMITH | | | 2a. DATE OF DEATH MONTH DAY YEAR OCT. 12, 1982 | | | 2b. HOUR 12 ⁴⁸ P ^M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR SEPT. 17, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH COCKEYSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 205 WICKERSHAM WAY | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BETH. STZEL | |
| 13a. STATE MO. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN COCKEYSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William SMITH | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET MARSHALL | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213070144 | | 17. INFORMANT ADDRESS FAMILY RECORDS | | | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMATOSIS, PULMONARY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours 4 mos. | |
|--|--|--|--|

| | | | |
|---|--|--|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS INSULIN DEPENDENT | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-26, 1961, to 10-12, 1982, that (I) (we) last saw the deceased alive on 10-12, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Wm Carl Zebeling | | 22c. DATE SIGNED 10-15-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM CARL ZEBELING | | 22e. ADDRESS 7401 OSLER DRIVE, TOWSON | |

| | | | | | | | |
|--|--|-------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10-15-1982 | | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | | 23d. LOCATION CITY OR TOWN COUNTY STATE ESSEX BALTO. MARYLAND | |
| 24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF CHIMES 2325 YORK RD. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 20 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carick | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST DORA L. SNELL | | | | | MONTH DAY YEAR HOUR 10 16 82 5:40 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| F | | Black | | MONTH DAY YEAR 7 26 20 | | 62 YRS. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Baltimore County, MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Baltimore County General | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13a. STATE | | | | | 13c. CITY OR TOWN | | | | |
| Maryland | | | | | Baltimore | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST Carl Snell | | | | | FIRST MIDDLE LAST Mary Anderson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | N/A | | Ruby Richardson 3811 Garrison Blvd | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) <u>ANoxic BRAIN DAMAGE</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOGENIC SHOCK</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ISCHEMIC HEART DISEASE</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS ; OBESITY</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/16/82</u> to <u>10/16/82</u> , that (I) (we) lost saw the deceased alive on <u>10/16/82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Archie Kerman Choyne M.D.B.S.</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>10/16/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A.K. CHOPRA</u> | | | | | | 22e. ADDRESS <u>BALTIMORE COUNTY GEN. HOSP</u> <u>RANDALLSTOWN MD 21133</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 10/20/82 | | Mount Auburn Cem | | Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| Wm. C. March F/H 1101 E. North Avenue | | | | | | 10/18/1982 <u>John J. Connel</u> | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| FOR Item 5 & 6 Phone 1-STATE REGISTRAR 11-17-82 cn | | | | | | | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 2 2 5 3 5 6 REG. NO. | |
|--|--|------------------|--|---|--|--|--|---|--|---|--|--|--|---|--|---|--|-----------------|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROLAND SNOWDEN | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10 29 19 82 | | | | | | | | | | 2b. HOUR M 1:37 a M | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 17 82 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS 1 43 | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED WIDOWED NEVER MARRIED DIVORCED <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 29 19 82 | | 2d. HOUR a M | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BABY | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13a. STATE MARYLAND | | | | 13b. CITY OR TOWN BALTIMORE | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13d. STREET ADDRESS 22 A CEDER HEIGHTS COURT | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR ROLAND SNOWDEN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FABIE JOHNSON | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | |
| 17. INFORMANT MR ARTHUR SNOWDEN | | | | ADDRESS 22 A CEDER HTS CT | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Ann M. Dixon</i> | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | DATE SIGNED 10-29-82 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 11/1/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY Whitman Mem. Park | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Hines | | | | ADDRESS 2222 W. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR NOV 5 1982 | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i> | | | | | | | | | |

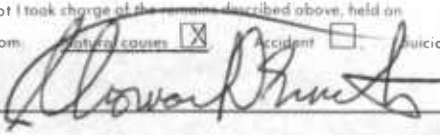

11-17-50
11-17-50
11-17-50



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 5 3 5 7 | |
|---|--|------------------|--|---|--|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur Lehman Sprinkle Sr. | | | | | | | | | | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 10 26 1982 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3/25/1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 2b. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 10 26 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY Carpenter | | |
| 13a. STATE Pennsylvania | | | 13b. COUNTY Indiana | | | 13c. CITY OR TOWN Indiana | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George W Sprinkle | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Alice Sherman | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 200-05-5075 | | |
| 17. INFORMANT Mabel Sprinkle | | | ADDRESS Indiana, PA 15701 | | | 17. INFORMANT Mabel Sprinkle | | | ADDRESS 2085-422 West | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the deceased described above, held on death resulted from <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | DATE SIGNED 10/27/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. | | | | Balto., MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/30/82 | | | 23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Indiana Indiana Penn. | | |
| 24. FUNERAL DIRECTOR NAME Loring Byers, Funeral Directors, Inc. | | | | | | 25a. DATE REC'D BY REGISTRAR NOV 1 1982 | | | 25b. REGISTRAR'S SIGNATURE  | | |
| 8728 Liberty Rd. Randallstown, Md. 21133 | | | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|--|--|---|-----------------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Constance S. STALNAKER | | | 2a. DATE OF DEATH MONTH DAY YEAR October 23, 1982 | | 2b. HOUR MIN. 11:55a | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10-20-20 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 62 |
| 7. BIRTHPLACE STATE OR FOREIGN Balto. City | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. |
| 10. CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Time Keeper | | 12b. KIND OF BUSINESS OR INDUSTRY Chessie System |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph S. Johnson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Riley | | 16. STREET ADDRESS 4504 Anntana Ave.-21206 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-01-0951 | | 17. INFORMANT ADDRESS William A. Stalnaker 4504 Anntana Ave. 21206 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

1889

IMMEDIATE CAUSE (a) **Cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Transitional cancer of bladder**

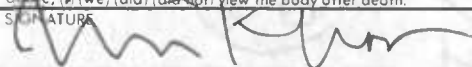
DUE TO, OR AS A CONSEQUENCE OF


(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

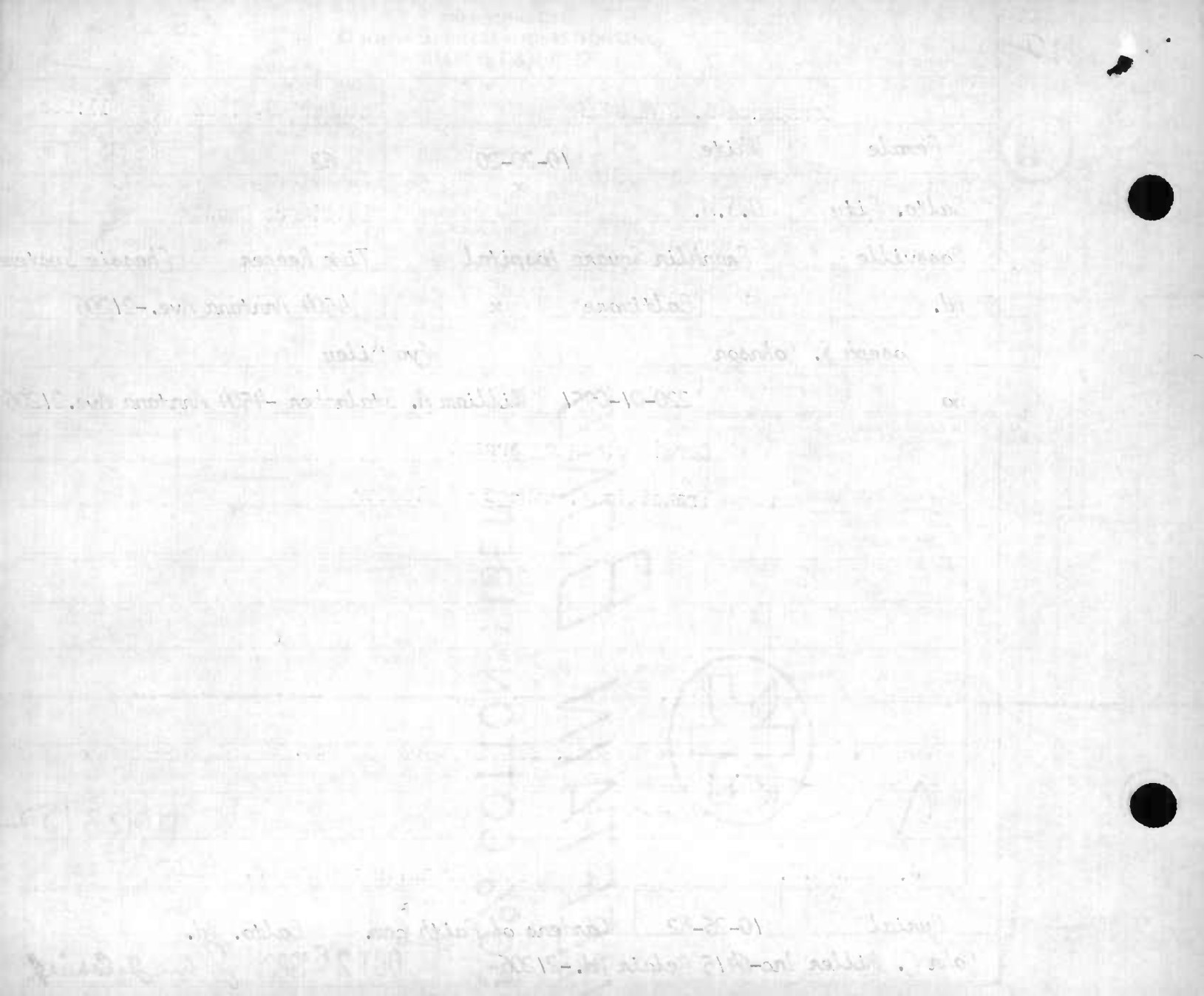
| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 23 , 19 82 , to Oct. 23 , 19 82 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Oct. 23 , 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE  | | | | DEGREE | | 22c. DATE SIGNED 10/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Khan M.D. | | | | 22e. ADDRESS 9000 Franklin Square Dr. 21237 | | | |

| | | | | | | | |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-26-82 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 26 1982 | | 25b. REGISTRAR'S SIGNATURE  | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25359 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) WALTER E STANZEL | | | | | | | | | | 2a. DATE KNOWN OF DEATH October 5 1982 | |
| 2b. HOUR 8 P M | | | | | | | | | | 2c. DATE PRONOUNCED DEAD October 5 1982 | |
| 2d. HOUR 8 P M | | | | | | | | | | 2e. DATE PRONOUNCED DEAD October 5 1982 | |
| 3. SEX Male | | | | | | | | | | 3b. RACE Cauc. | |
| 4. DATE OF BIRTH 5 10 1927 | | | | | | | | | | 4b. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | |
| 5. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | | | | | | | | | 5b. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | | | | | | | | 6b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 7. CITY OR TOWN OF DEATH TOWSON | | | | | | | | | | 7b. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N CHARLES ST GBMC | |
| 8. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Engineer | | | | | | | | | | 8b. KIND OF BUSINESS Material Handling | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY | | | | | | | | | | 9b. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY | |
| 10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 10b. CITY OR TOWN Timonium | |
| 10a. STATE Maryland | | | | | | | | | | 10b. CITY OR TOWN Timonium | |
| 10c. STREET ADDRESS 316 Galway Road, #21093 | | | | | | | | | | 10d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 11. FATHER'S NAME Walter E. Stanzel | | | | | | | | | | 11b. MOTHER'S MAIDEN NAME Valeria Bell Kreidler | |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | | | | | | | 12b. SOCIAL SECURITY NO. 113-14-9844 | |
| 13. IF YES, GIVE WAR OR DATES WW II | | | | | | | | | | 13b. INFORMANT Margaret M. Stanzel, 316 Galway Road | |
| 14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Coronary Heart Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Acute myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Sudden | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 15a. DATE OF OPERATION | | | | | | | | | | 15b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 15c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 16a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 16b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | |
| 16c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 17a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 17b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| 17c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 20a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell M.D. DEPUTY MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 10/5/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 10/8/1982 | |
| 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem. | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME J. E. Lowell Lemmon ADDRESS 10 W. Padonia Rd. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT. 7 1982 | |
| 25b. REGISTRAR'S SIGNATURE John J. Cawley | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the medical director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. Page 56 should be retained by the funeral director. Page 57 should be retained by the funeral director. Page 58 should be retained by the funeral director. Page 59 should be retained by the funeral director. Page 60 should be retained by the funeral director. Page 61 should be retained by the funeral director. Page 62 should be retained by the funeral director. Page 63 should be retained by the funeral director. Page 64 should be retained by the funeral director. Page 65 should be retained by the funeral director. Page 66 should be retained by the funeral director. Page 67 should be retained by the funeral director. Page 68 should be retained by the funeral director. Page 69 should be retained by the funeral director. Page 70 should be retained by the funeral director. Page 71 should be retained by the funeral director. Page 72 should be retained by the funeral director. 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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 6 0 | | | |
|--|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MOLLIE STEINER | | | | 2a. DATE OF DEATH MONTH DAY YEAR THURS. OCT. 7, 1982 | | 2b. HOUR 3 P.M. | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAR. 15, 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH PIKESVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DAVID HIRSCHORN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NESSIE LANDSBURGH | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 056-52-3884 | | 17. INFORMANT ADDRESS SOL BLOCK 6715 DARWOOD DR. (21209) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 Cerebrovascular accident IMMEDIATE CAUSE (a) Cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular arteriosclerotic disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION 2/9/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1 19 74 , to 10/7 19 82 , that (I) (we) lost saw the deceased alive on 10/7 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE H. Ronald Friedman MD | | DEGREE MD | | 22c. DATE SIGNED 10/7/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Ronald Friedman | |
| 22e. ADDRESS 6715 Park Heights Ave 21205 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL/REMOVAL | | | | | |
| 23b. DATE OCT. 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY NEW MT. CARMEL | | 23d. LOCATION CITY OR TOWN COUNTY STATE QUEENS, L.I. N.Y. | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. | | | | 25. DATE RECEIVED BY REGISTRAR OCT 13 1982 | | | |
| 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | REGISTRAR'S SIGNATURE John J. Carney | | | |



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1911
[Signature]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 2 5 3 6 1

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|-----------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth M. Stern | | | 2a. DATE OF DEATH MONTH 10 DAY 19 YEAR 82 | | | 2b. HOUR M | | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 12 DAY 28 YEAR 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS HOURS 0 MIN 0 | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Riverview Nursing Ctr. Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3906 PARKSIDE DR. 21206 | | |
| 14. FATHER'S NAME FIRST VIKTOR MIDDLE SHIMEK LAST SHIMEK | | | | 15. MOTHER'S MAIDEN NAME FIRST MARIE MIDDLE DUSEK LAST DUSEK | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO 215074318 | | 17. INFORMANT ADDRESS JAMES DAUSES 3906 PARKSIDE DR. | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 11 , 19 77 , to Oct. 19 , 19 82 , that (I) (we) last saw the deceased alive on Oct. 12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE M. Rainess MD | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/19/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORRIS RAINESS, MD. | | | | 22e. ADDRESS 1105 OLD EASTERN AVE. Balto. - Md. 21221 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 10/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | | 23d. LOCATION CITY OR TOWN BALTO. COUNTY ---- STATE MD. | | | | |
| 24. FUNERAL DIRECTOR John J. Conner | | | | ADDRESS 1211 Chesapeake Ave. 21237 | | 25a. DATE REC'D. BY REGISTRAR OCT 20 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | |

MEDICAL CERTIFICATION

To be completed by medical examiner only. If death is due to natural causes, this section may be omitted.

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified.

77

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 6 2

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HENRY STEUER | | | 2a. DATE OF DEATH MONTH DAY YEAR October 16, 1982 | | | 2b. HOUR 6:30 A.M. | | | |
| 3 SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 17, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JEWISH CONVALESCENT CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY HARDWARE | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3402 WILD CHERRY RD. #21207 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ISRAEL STEUER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HENDEL UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 059-10-1597 | | 17. INFORMANT ADDRESS MRS. HARRIET YELLIN 3402 WILD CHERRY RD. BALTO., MD 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MI 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Yellin | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/4 , 19 79 , to 10/10 , 19 82 , that (1) (we) lost saw the deceased above (1) (we) (did) (did not) view the body after death. 9 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE S. H. Malinow | | | | | | DEGREE ATTENDING PHYSICIAN | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANFORD MALINOW, M.D. | | | | | | 22e. ADDRESS 3635 OLD COURT RD. BALTO., MD 21208 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 10-18-82 | | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 20 1982 | | 25b. REGISTRAR'S SIGNATURE Joan J. Conner | |

33

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

FOR COTTON

WATER
FERTILIZER
COTTON



1900-1901

2-2-19

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

2 5 3 8

REG. NO.

25363

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|--|---|---|--|--|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Aaron Stewart Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 11 82 | | | 2b. HOUR M M | |
| 3. SEX male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 4 21 16 | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Towson, Md- | 7c. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrison Valley Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elizah Stewart | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marietta Bonds | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No | | 16b. SOCIAL SECURITY NO. 219-05-0915 | | 17. INFORMANT ADDRESS Aaron Stewart Jr. 4722 Kimberleigh Rd. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

1919

IMMEDIATE CAUSE (a)

Brain cancer

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>L. Boas</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED OCT 14, 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. BOAS MD | | 22e. ADDRESS 50 Scott Ave RD Coodeville MD 21030 | | | | | |

| | | | | | | | |
|--|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus md | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March f/h | | | | ADDRESS 1101 E. North Ave | | 25a. DATE REC'D. BY REGISTRAR OCT 15 1982 | |
| 25b. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 6 4

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|---------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) EUGENE F. STEWART | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-24-82 | | 2b. HOUR 10:45A | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 07 11 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 NORTH CHARLES STREET | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Stewart | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Curtis | | 16. STREET ADDRESS 4732 Old York Road | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-0062 | | 17. INFORMANT ADDRESS Mary A. Stewart 4732 Old York Road | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) **MYOCARDIAL INFARCTS AND PULMONARY EMBOLI**
DUE TO, OR AS A CONSEQUENCE OF
(b) **ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (we) attended the deceased from 9-26 , 19 82 , to 10-24 , 19 82 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Charles C. Leom, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|--|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR OCT 26 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-24-82 10:45A

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TOWN

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ASSOCIATED INTERESTS AND FOLLOWING

ADDITIONAL INFORMATION TO BE FURNISHED

10-24-82

10-24-82

10-24-82



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 3 6 5 REG. NO. | |
|--|--|---|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE E STOUGH | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-20-82 | | | 2b. HOUR 7:05am | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR February 27, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wholesale Dep't. | | 12b. KIND OF BUSINESS OR INDUSTRY Good Humor | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. CITY Baltimore | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ed Noble Stough | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Brown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-01-5237 | | 17. INFORMANT ADDRESS Mrs. Helen W. Stough 611 Fairway Drive | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-12, 1982, to 10-20, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 10-20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Natividad D. de Leon | | | | | DEGREE M.D. | | | 22c. DATE SIGNED 10/20/82 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATIVIDAD D. DE LEON | | | | | 22e. ADDRESS 7620 YORK ROAD TOWSON MD 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10-22-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | | 23d. LOCATION Baltimore COUNTY Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 21 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 3 6 6 REG. NO. | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|--|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Raymond George Streib | | | | | | | | | | 2a. DATE OF DEATH October 20, 1982 | | | | 2b. HOUR 10:45 AM | |
| 3 SEX Male | | 4 RACE Caucasian | | 5 DATE OF BIRTH Nov. 9, 1908 | | 6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Catonsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 67 Edmondson Ridge Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman Balt. | | 12b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 67 Edmondson Ridge Road | | | | | | | |
| 14. FATHER'S NAME Jacob P. Streib | | | | 15. MOTHER'S MAIDEN NAME Dorothea L. Spittel | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17 INFORMANT Mrs. L. Mae Streib | | ADDRESS Same as # 13 | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes Mellitus</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 12, 1981</u> to <u>October 20, 1982</u> , that (I) (we) lost saw the deceased alive on <u>October 19, 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>James E. Rowe</u> | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 10/21/82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Rowe, M.D. | | | | 22e. ADDRESS 413 Commonwealth Ave. Balt, MD 21228 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME MacNabb Funeral Home | | | | ADDRESS Catonsville, Md. | | 25a. DATE REC'D. BY REGISTRAR OCT 21 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DUNCAN L STUBBS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-21-82 2b. HOUR 4:10 M | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 8, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8b. CITIZEN OF WHAT COUNTRY? U.S. A. | | 8c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Linen Thread Co. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Woodlawn | | 13e. STREET ADDRESS 2537 Cedar Drive 21207 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert M. Stubbs | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence M. Siefer | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-03-8318A | | 17. INFORMANT ADDRESS Mrs. Charlotte Stubbs 2537 Cedar Drive Woodlawn, Maryland 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting aneurysm of thoracic aorta with peripheral artery disease DUE TO, OR AS A CONSEQUENCE OF (b) Chronic pulmonary emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4410 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pulmonary emphysema Hypertension | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9-30-1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-30-1982 to 10-21-1982 , that (I) (we) last saw the deceased alive on 10-21-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Soomehu L Hong | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 10-21-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOONCHUL HONG | | | | | 22e. ADDRESS Baltimore County General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-25-82 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore MD | | | |
| 24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. | | | | | 25. ADDRESS 8728 Liberty Road Randallstown, MD. 21133 | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

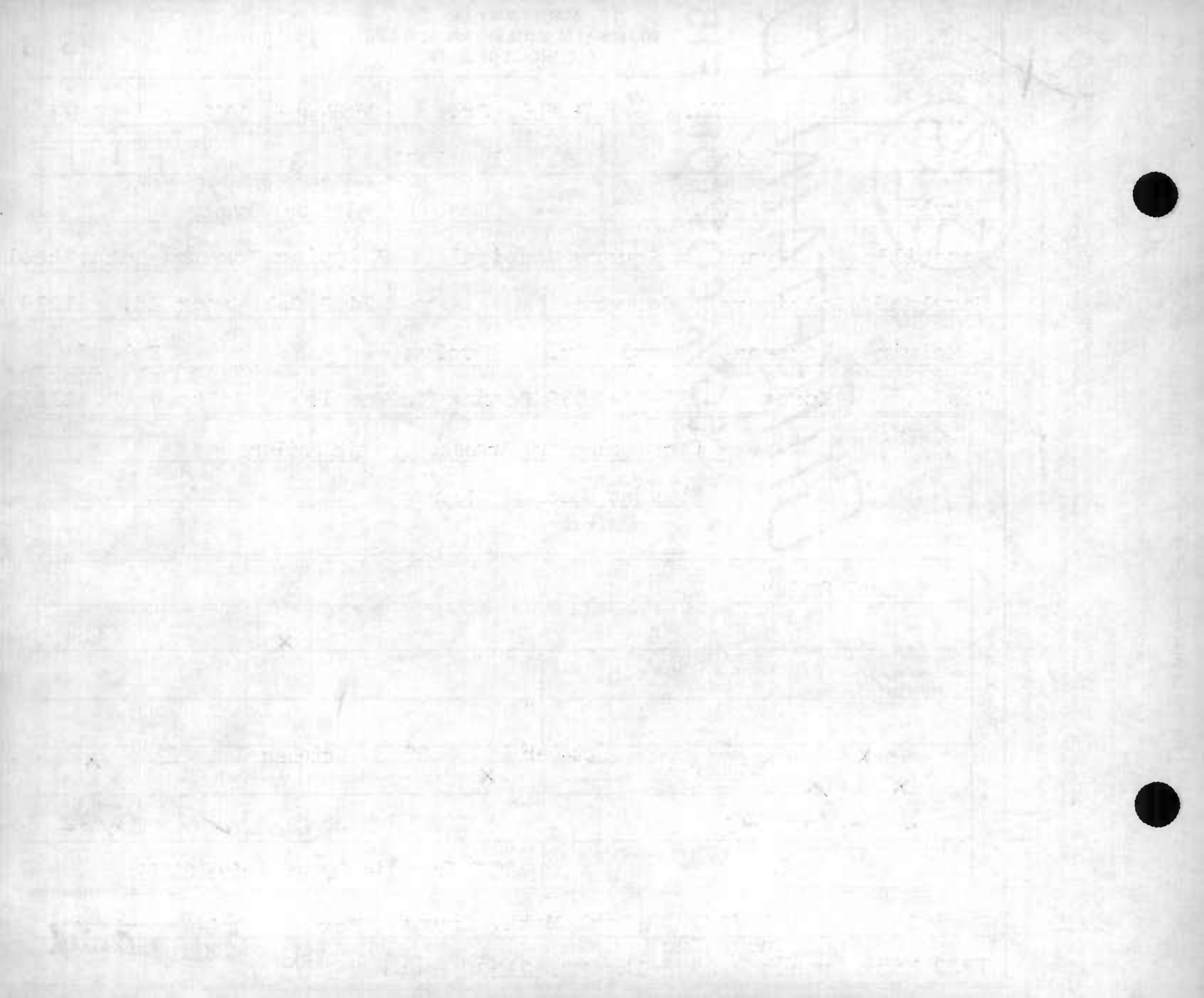
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 6 8

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MELVIN BATEMAN TEMPLE, Jr. | | 2a. DATE OF DEATH MONTH DAY YEAR October 6, 1982 | | 2b. HOUR 9:16a M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 1 1931 | | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Rossville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipping Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Edgemere | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 2403 Oak Manor Rd. | | 13f. CITY OR TOWN Baltimore | | 13g. STATE MD. | | 13h. ZIP CODE 21219 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Melvin Bateman Temple, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Z. Zulauf | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea | | 17. INFORMANT Deanna M. Temple | | ADDRESS 2403 Oak Manor Rd Balto., MD. 21219 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest; Hepatic Failure 4275 DUE TO, OR AS A CONSEQUENCE OF (b) Bleeding Duodenal Ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Renal Failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 4 , 19 82 , to October 6 , 19 82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 6 , 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE J. Taylor MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10/6/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Taylor | | | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/8/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Fork Meth. Church | | 23d. LOCATION CITY OR TOWN COUNTY STATE Fork Baltimore MD | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 8 1982 | | | |
| 7922 Wise Avenue Dundalk, MD. 21222 | | | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 6 9

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) DOROTHY TERPAY | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-24-82 | | | 2b. HOUR 545 A M | | | | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 16 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN Pa. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MULTI-MEDICAL NURSING CTR. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian | | 12b. KIND OF BUSINESS OR INDUSTRY School | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY HART | | 13c. CITY OR TOWN Abingdon | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 132-D Waldon Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILKINSON Edward Lagrange | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Cover | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | 16b. SOCIAL SECURITY NO. 280-30-8862 | | 17. INFORMANT ADDRESS Mr. Peter Terpay (Same as #13.) | | | | | |

| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pleural Effusion DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Osteogenic Sarcoma | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 22 19 92 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 , 19 92 , to 10 , 19 92 , that (I) (we) last saw the deceased alive on 10/22 , 19 92 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Alan M. Sidorofsky MD | | | | DEGREE MD | | 22c. DATE SIGNED 10/25/92 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN M SIDOROVSKY | | | | 22e. ADDRESS 1708 WHITEHEAD RD BALTIMORE MD | | | |

| | | | | | | | |
|--|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 10/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md. | | | | 25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE NOV 4 1982 [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shown any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 2 5 3 7 0
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Augusta Elizabeth Thistel | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 14 82 | | 2b. HOUR 430 A.M. | | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3 25 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Md CO. MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Karl Schmidt | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rukelschause | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 214-34-3071 | | 17. INFORMANT ADDRESS Mr. Carl I. Thistel 724 E. Lake Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June , 19 78 , to 10/14 , 19 82 , that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Dr. Eddie NaKhuda M.D. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/14/82 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-16-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Maryland | | ADDRESS 1050 York Road | | 25a. DATE REC'D. BY REGISTRAR OCT 18 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST ETHEL A. | | MIDDLE THOMAS | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR 10-28-82 | | | | 2b. HOUR 12:40 N M | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Randalls town | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY CARROLL | | 13c. CITY OR TOWN Sykesville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 6540 Church St. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ORA | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST COLA May WALKING | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220 032725 | | 17. INFORMANT ADDRESS James Thomas, Sr. Sykesville, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) UPPER G.I. BLEEDING DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BLEEDING ESOPHAGEAL VARICES (c) NO GASTRIC ULCER | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITIONS MUST BE LISTED) LIVER CIRRHOSIS, DIABETES MELLITUS, INTRAVASCULAR DEGENERATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPTIC YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF EXAMINATIONS WERE USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-27 19 82 to 10-28 19 82, that (I) (we) lost saw the deceased alive on 10-28 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Orlando B. Conway, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 10-28-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. CONWAY, M.D. | | 22e. ADDRESS BEGH - RANDALLSTOWN MD. 21133 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-30-82 | | 23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Nancy W. Haight | | ADDRESS Sykesville Md. | | 25. DATE REC'D. BY REGISTRAR NOV 1 1982 | | | | | | | | | |
| 25. REGISTRAR'S SIGNATURE John J. Conner | | | | | | | | | | | | | |

BP

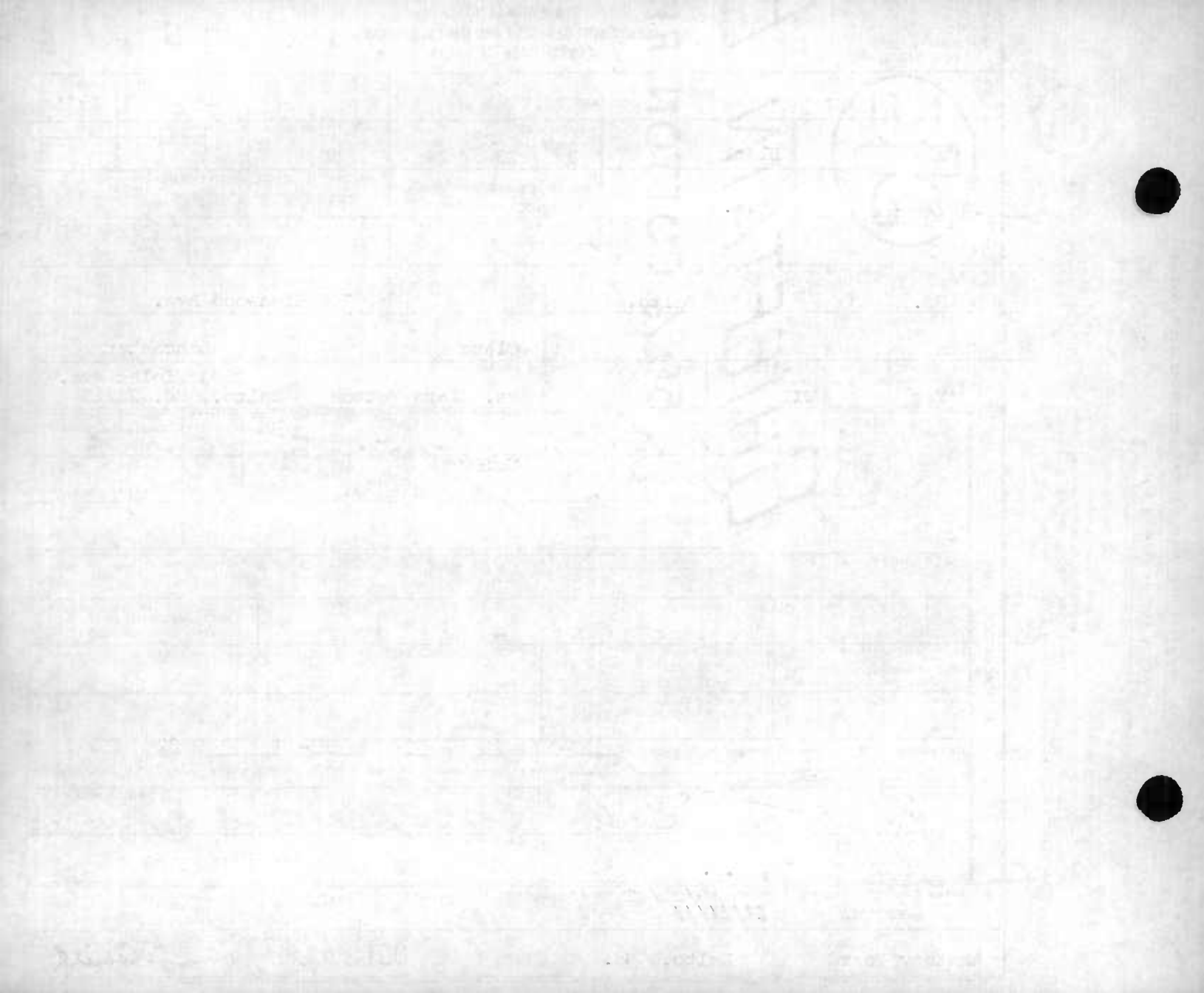
RELEASED TO ANATOMY BOARD OF MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 3 7 2 | |
|---|--|--|--|---|---|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) CHRISTOPHER THOMPSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-20-82 | | | 2b. HOUR 1:15am | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 3 20 24 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 706 Glenwood Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Lancaster | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WWII | | 17. INFORMANT ADDRESS Mrs. Clara Watson Balto., Md. 21215 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) METASTATIC CARCINOMATOSIS CARCINOMA OF THE COLON DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon DUE TO, OR AS A CONSEQUENCE OF (c) 2 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-19 , 19 82 , to 10-20 , 19 82 , that <input checked="" type="checkbox"/> (we) lost above the deceased alive on 10-20 , 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | | | | | |
| 22b. SIGNATURE Francis T. Daly | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 10.20.82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS T DALY, M.D. | | | | 22e. ADDRESS 7620 YORK ROAD TOWSON MD 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 10/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | 25a. DATE REC'D. BY REGISTRAR OCT 26 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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6

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 7 3

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ida Louise Tierney | | | 2a. DATE OF DEATH MONTH DAY YEAR October 20, 1982 | | 2b. HOUR 7:00p M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 25, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH 21234 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1718 Weston Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN 21234 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Silvio Carraro | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria T. Giacomini | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----212-16-3872 | | 17. INFORMANT ADDRESS William F. Tierney 1718 Weston Ave 21234 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1991

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

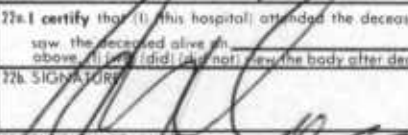
DUE TO, OR AS A CONSEQUENCE OF


(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | | | |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) I (we) did (did not) see the body after death. | | | | | |
| 22b. SIGNATURE  | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. E. Cocco, M.D. | | 22e. ADDRESS 20 East Eager Street 5 39-3035 | | | |

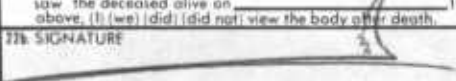
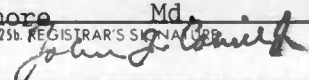
| | | | |
|--|---------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL SPECIES Burial | 23b. DATE Oct. 25, '82 | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland |
| 24. FUNERAL DIRECTOR NAME William E. Johnson | | 25a. DATE REC'D. BY REGISTRAR OCT 22 1982 | 25b. REGISTRAR'S SIGNATURE  |
| ADDRESS 8521 Loch Raven Blvd. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 2 2 5 3 7 4 | | | | | | |
|--|--|---|--|---|--|---|---|--|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM BREWER TILGHMAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 30 82 | | | | | 2b. HOUR 4⁵⁵ PM | |
| 3. SEX Male | | 4. RACE Cau. | | 5. DATE OF BIRTH MONTH DAY YEAR 6 1 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS HOSPICE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Electrical Contractor | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4307 Nicholas Ave. 21206 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Ogle Tilghman Jr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Brewer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | | 16b. SOCIAL SECURITY NO. 215-01-7583 | | 17. INFORMANT ADDRESS Mrs. Monica Heckrotte 40 Mulard Ct. 21146 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADVANCED CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE  | | | | | | | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Nov. 2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME Mitchell Wiedefeld | | | | | | ADDRESS 6500 York Rd. | | | 25a. DATE REC'D. BY REGISTRAR NOV 8 1982 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE  | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|---|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 2 5 3 7 5 CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | |
| CHRISTINA TINKER | | | | | October 3, 1982 | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 2b. HOUR | |
| Female | | Black | | 9 13 21 | | 61 YRS | | 2:p M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Baltimore County MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Franklin Square Hospital | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | Balt | | Baltimore | | | | 6089 Marquette Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| William F. Franklin | | | | Ida V. Ppwell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | 217-14-0417 | | Barbara Scott 6089 Marquette Rd 21206 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>refractory Ventricular Arrhythmia</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 1,</u> 19 <u>82</u> , to <u>October 3,</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>October 3,</u> 19 <u>82</u> , and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above, <u>X</u> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| <u>Donald E. Kerr M.D.</u> | | | | | | | | 10/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| Donald E. Kerr M.D. | | | | | 9000 Franklin Square Drive 21237 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 10/8/82 | | King Memorial Pk. | | Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | |
| Wm. C. March F/H Inc, 1101 E. North Ave | | | | | OCT 5 1982 John J. Cahill | | | | |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 8 2 2 5 3 7 6 | | | | | | |
|---|--|---|--|--|--|---|---|---|---|--|--|
| FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Domerick Tisa</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 5 82 | | | | | 2b. HOUR 12:55 P.M. | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR June 6, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Mass.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Randallstown</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore County General Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Restaurant Owner</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Mike's Pizza</i> | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS <i>4113 Springsleigh Road 21133</i> | | | | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Randallstown</i> | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Michael Tiso</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lenora Cerrolo</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>130-01-1110</i> | | 17. INFORMANT <i>Mrs. Shirley Tiso</i> ADDRESS <i>4113 Springsleigh Road Randallstown, MD. 21133</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4960 COPD with acute respiratory failure and shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>failure and shock</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute Renal failure</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-25-</i> 19 <i>82</i> , to <i>10-5-</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>10-5-</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>R.M. Shah</i> DEGREE | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED <i>10-5-82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.M. SHAH.</i> | | | | | 22e. ADDRESS <i>13 C.G.H. RANDALLSTOWN OLD COURT RD 3 (near RD</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Entombment</i> | | 23b. DATE <i>10-9-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Mausoleum</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City, Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>Loring Byers Funeral Directors Inc.</i> ADDRESS <i>8728 Liberty Road Randallstown, MD. 21133</i> | | | | | 25a. DATE REC'D. BY REGISTRAR <i>OCT 8 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i> | | | | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 7 7 | | | |
|--|--|--|--|---|--|---|--|
| FOR 1. STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| GEORGE J TITELMAN | | | | 10 29 82 11:20 P.M. | | | |
| 1. SEX M ALE | | 4. RACE WHITE | | 5. DATE OF BIRTH JAN. 31, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP. | | 12a. USUAL OCCUPATION (GIVE WORK OR BUSINESS DURING LIFE) TAXI CAB OWNER & DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MEYER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA UNKNOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 213-28-7906 | | 17. INFORMANT ADDRESS MRS. HELEN TITELMAN 5709 RANNY RD. BALTO., MD 21209 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2028 IMMEDIATE CAUSE (a) Malignant lymphoma. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION 10.5.82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric outlet obstruction | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-2 19 82, to 10-29 19 82, that (I) (we) last saw the deceased alive on 10-29 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE RAYADURG GRA | | | | DEGREE M.D. | | 22c. DATE SIGNED 10.29.82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS BALT County GENL Hospital. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE OCT. 31, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25. DATE REC'D. BY REGISTRAR NOV 3 1982 | | | |

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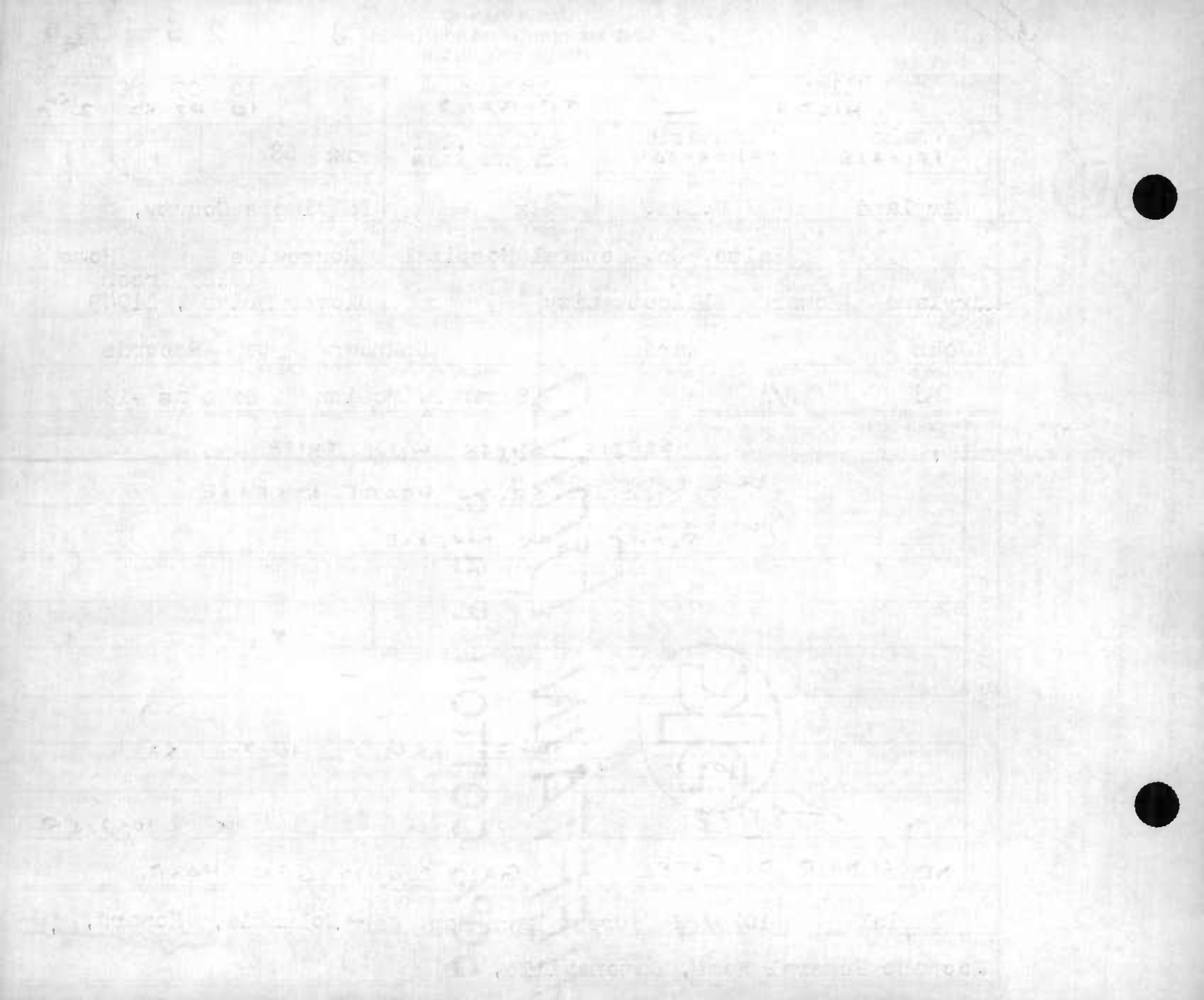
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 7 8 | |
|---|--|--|--|--|--|
| FOR 1- STATE REGISTRAR | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MIDDLE | | 2a. DATE OF DEATH | |
| Hilda HILDA | | — | | 10 th 07 th 82 10 07 82 | |
| 3 SEX Female FEMALE | | 4 RACE Caucasian CAUCASIAN | | 5. DATE OF BIRTH Feb. 24, 1914 000XXXXXX | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 AGE (IN YEARS LAST BIRTHDAY) XXS 68 YRS | |
| 9. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Howard | | 13c. STREET ADDRESS 10129 Green Clover Drive, 21043 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Harden | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown to Records | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Susan P. McGinn Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY 4140 IMMEDIATE CAUSE (a) SEPTIC SHOCK WITH COMA DUE TO OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE. DUE TO OR AS A CONSEQUENCE OF (c) PEPTIC ULCER DISEASE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) — | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-3-1982 to 10-7-1982, that (I) (we) last saw the deceased alive on 10-7-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Sudhir D. Patel</i> | | DEGREE | | 22c. DATE SIGNED 10-7-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SUDHIR D. PATEL | | 22e. ADDRESS BAL. COUNTY GEN. HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Mem. Gard. | |
| 24. FUNERAL DIRECTOR NAME MacNabb Funeral Home, | | ADDRESS Catonsville, MD | | 23d. LOCATION CITY OR TOWN COUNTY STATE Columbia, Howard, MD | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| OCT 11 1982 | | <i>[Signature]</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 7 9 | | | |
|--|---|---|--|---|--|--|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Gertrude Turner | | | | 2a. DATE OF DEATH MONTH DAY YEAR Oct. 14 1982 | | 2b. HOUR 12 30 P ^M | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 9 27 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. Md. | | | |
| 10. CITY OR TOWN OF DEATH Kingsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7019 Sunshine Ave. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife | | 12b. KIND OF BUSINESS OR INDUSTRY Home maker | |
| 13a. STATE Md. | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Kingsville | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Luther Eckert | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Woolford | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 220-01-3796 | | 17. INFORMANT ADDRESS Mrs. Marline Buerhaus, Kingsville, Md. 21087 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCUD</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Large Sacral Decubitus</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 10 - 3</u> , 19 <u>82</u> , to <u>10 - 14</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>10 - 3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>F. Sanzaro MD</u> | | | | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. SANZARO MD | | | | 22e. ADDRESS 3313 PAPER MILL RD PIREUX 81137 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 18, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill M. G. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME E. F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 19 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 2 | 5 | 3 | 8 | 0 |
|---|--|---|--|---|--|---|--|--|--|--|---|--|---|----------------------------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dee L. Tyler | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR October 1 1982 | | | | 2b. HOUR 3 ³⁰ P.M. | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 31 1985 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) APPLETON, ARK. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FOREST HAVEN NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER-CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY RETIRED | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE ARKANSAS 13b. COUNTY POPE | | | | 13c. CITY OR TOWN RUSSELLVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS TYLER RD. @ E. HWY #64 | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST J. LAFAYETTE TYLER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA G. BARTLETT | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 430-26-0308A | | 17. INFORMANT (SON) MR. JOHN TYLER | | ADDRESS 2316 N. ROLLING RD. BALTO, MD. 21207 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Pneumonia - sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent Multiple Strokes DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| 19a. DATE OF OPERATION NO | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 82 to Oct 1 19 82, that (I) (we) lost saw the deceased dying on Sept 20 19 82 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | 22b. SIGNATURE Harold B. Bob MD | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10-1-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold B. Bob MD | | | | 22e. ADDRESS 7220 Park Heights 21208 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 10/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE RUSSELLVILLE POPE ARK. | | | | | | | | |
| 24. FUNERAL DIRECTOR E. BARNES NAME FLEMING FUNERAL SERVICE ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR OCT 13 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | | | | | | |

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1952-1953, 1954-1955, 1956-1957, 1958-1959, 1960-1961, 1962-1963, 1964-1965, 1966-1967, 1968-1969, 1970-1971, 1972-1973, 1974-1975, 1976-1977, 1978-1979, 1980-1981, 1982-1983, 1984-1985, 1986-1987, 1988-1989, 1990-1991, 1992-1993, 1994-1995, 1996-1997, 1998-1999, 2000-2001, 2002-2003, 2004-2005, 2006-2007, 2008-2009, 2010-2011, 2012-2013, 2014-2015, 2016-2017, 2018-2019, 2020-2021, 2022-2023, 2024-2025, 2026-2027, 2028-2029, 2030-2031, 2032-2033, 2034-2035, 2036-2037, 2038-2039, 2040-2041, 2042-2043, 2044-2045, 2046-2047, 2048-2049, 2050-2051, 2052-2053, 2054-2055, 2056-2057, 2058-2059, 2060-2061, 2062-2063, 2064-2065, 2066-2067, 2068-2069, 2070-2071, 2072-2073, 2074-2075, 2076-2077, 2078-2079, 2080-2081, 2082-2083, 2084-2085, 2086-2087, 2088-2089, 2090-2091, 2092-2093, 2094-2095, 2096-2097, 2098-2099, 2100-2101, 2102-2103, 2104-2105, 2106-2107, 2108-2109, 2110-2111, 2112-2113, 2114-2115, 2116-2117, 2118-2119, 2120-2121, 2122-2123, 2124-2125, 2126-2127, 2128-2129, 2130-2131, 2132-2133, 2134-2135, 2136-2137, 2138-2139, 2140-2141, 2142-2143, 2144-2145, 2146-2147, 2148-2149, 2150-2151, 2152-2153, 2154-2155, 2156-2157, 2158-2159, 2160-2161, 2162-2163, 2164-2165, 2166-2167, 2168-2169, 2170-2171, 2172-2173, 2174-2175, 2176-2177, 2178-2179, 2180-2181, 2182-2183, 2184-2185, 2186-2187, 2188-2189, 2190-2191, 2192-2193, 2194-2195, 2196-2197, 2198-2199, 2200-2201, 2202-2203, 2204-2205, 2206-2207, 2208-2209, 2210-2211, 2212-2213, 2214-2215, 2216-2217, 2218-2219, 2220-2221, 2222-2223, 2224-2225, 2226-2227, 2228-2229, 2230-2231, 2232-2233, 2234-2235, 2236-2237, 2238-2239, 2240-2241, 2242-2243, 2244-2245, 2246-2247, 2248-2249, 2250-2251, 2252-2253, 2254-2255, 2256-2257, 2258-2259, 2260-2261, 2262-2263, 2264-2265, 2266-2267, 2268-2269, 2270-2271, 2272-2273, 2274-2275, 2276-2277, 2278-2279, 2280-2281, 2282-2283, 2284-2285, 2286-2287, 2288-2289, 2290-2291, 2292-2293, 2294-2295, 2296-2297, 2298-2299, 2300-2301, 2302-2303, 2304-2305, 2306-2307, 2308-2309, 2310-2311, 2312-2313, 2314-2315, 2316-2317, 2318-2319, 2320-2321, 2322-2323, 2324-2325, 2326-2327, 2328-2329, 2330-2331, 2332-2333, 2334-2335, 2336-2337, 2338-2339, 2340-2341, 2342-2343, 2344-2345, 2346-2347, 2348-2349, 2350-2351, 2352-2353, 2354-2355, 2356-2357, 2358-2359, 2360-2361, 2362-2363, 2364-2365, 2366-2367, 2368-2369, 2370-2371, 2372-2373, 2374-2375, 2376-2377, 2378-2379, 2380-2381, 2382-2383, 2384-2385, 2386-2387, 2388-2389, 2390-2391, 2392-2393, 2394-2395, 2396-2397, 2398-2399, 2400-2401, 2402-2403, 2404-2405, 2406-2407, 2408-2409, 2410-2411, 2412-2413, 2414-2415, 2416-2417, 2418-2419, 2420-2421, 2422-2423, 2424-2425, 2426-2427, 2428-2429, 2430-2431, 2432-2433, 2434-2435, 2436-2437, 2438-2439, 2440-2441, 2442-2443, 2444-2445, 2446-2447, 2448-2449, 2450-2451, 2452-2453, 2454-2455, 2456-2457, 2458-2459, 2460-2461, 2462-2463, 2464-2465, 2466-2467, 2468-2469, 2470-2471, 2472-2473, 2474-2475, 2476-2477, 2478-2479, 2480-2481, 2482-2483, 2484-2485, 2486-2487, 2488-2489, 2490-2491, 2492-2493, 2494-2495, 2496-2497, 2498-2499, 2500-2501, 2502-2503, 2504-2505, 2506-2507, 2508-2509, 2510-2511, 2512-2513, 2514-2515, 2516-2517, 2518-2519, 2520-2521, 2522-2523, 2524-2525, 2526-2527, 2528-2529, 2530-2531, 2532-2533, 2534-2535, 2536-2537, 2538-2539, 2540-2541, 2542-2543, 2544-2545, 2546-2547, 2548-2549, 2550-2551, 2552-2553, 2554-2555, 2556-2557, 2558-2559, 2560-2561, 2562-2563, 2564-2565, 2566-2567, 2568-2569, 2570-2571, 2572-2573, 2574-2575, 2576-2577, 2578-2579, 2580-2581, 2582-2583, 2584-2585, 2586-2587, 2588-2589, 2590-2591, 2592-2593, 2594-2595, 2596-2597, 2598-2599, 2600-2601, 2602-2603, 2604-2605, 2606-2607, 2608-2609, 2610-2611, 2612-2613, 2614-2615, 2616-2617, 2618-2619, 2620-2621, 2622-2623, 2624-2625, 2626-2627, 2628-2629, 2630-2631, 2632-2633, 2634-2635, 2636-2637, 2638-2639, 2640-2641, 2642-2643, 2644-2645, 2646-2647, 2648-2649, 2650-2651, 2652-2653, 2654-2655, 2656-2657, 2658-2659, 2660-2661, 2662-2663, 2664-2665, 2666-2667, 2668-2669, 2670-2671, 2672-2673, 2674-2675, 2676-2677, 2678-2679, 2680-2681, 2682-2683, 2684-2685, 2686-2687, 2688-2689, 2690-2691, 2692-2693, 2694-2695, 26

2017-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-104

0124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 2 5 3 8 1 | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES M VANARSDALE | | | 2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 22 1982 10 22 82 | | |
| 3. SEX MALE | | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 13, 1906 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. |
| 10. CITY OR TOWN OF DEATH TOWSON | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SOCIAL SECURITY | | | 12b. KIND OF BUSINESS OR INDUSTRY FED. GOV'T | | |
| 13a. STATE MO. | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN PARKVILLE |
| 14. FATHER'S NAME FIRST MIDDLE LAST GUY VanARSDALE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EFFIE HUFFMAN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 704-036858 | | 17. INFORMANT ADDRESS FAMILY RECORDS |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 POST RESUSITATION ENCEPHALOPATHY DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 8/24/1982, to 10/22/1982, that (we) last saw the deceased alive on 10/22/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE Akhok K. Chopra M.B.B.S. | | | | 22c. DATE SIGNED 10/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.K. CHOPRA | | | | 22e. ADDRESS ST. JOSEPH HOSPITAL 7620 YORK RD. TOWSON MD 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10-26-1982 | | 23c. NAME OF CEMETERY OR CREMATORY DULANY VALLEY | |
| 23d. LOCATION (CITY OR TOWN) COUNTY STATE Towson BALTO. MARYLAND | | 24. FUNERAL DIRECTOR NAME ADDRESS Evan Funeral Chapel 8800 Haydon | | | |
| 25a. DATE REC'D. BY REGISTRAR NOV 1 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conick | | | |

EX

DATE: OCTOBER 10, 1964
TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [illegible]

RE: [illegible]
[illegible]

ON [illegible]
[illegible]

IT IS REQUESTED THAT YOU
[illegible]

ADVISE THE BUREAU OF THE
[illegible]

YOUR OFFICE'S ACTION
[illegible]

VERY TRULY YOURS,
[illegible]

WILLIAM J. [illegible]
[illegible]

ENCLOSURE
[illegible]

100-443886-100
[illegible]

CHIEF MAIL

SO. COLL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

3

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 8 2

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Michael Edward VINCE | | | 2a. DATE OF DEATH MONTH DAY YEAR October 8, 1982 | | 2b. HOUR 2:55 a.m. |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 10 18 07 | | 6. AGE (IN YEARS, LAST BIRTHDAY) 74 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Worker | 12b. KIND OF BUSINESS OR INDUSTRY Aircraft | |
| 13a. STATE Md. | | 13b. COUNTY BALTO. | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Vince Joseph | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Horvatch | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unkn. | | 16b. SOCIAL SECURITY NO. 214-01-3018 | | 17. INFORMANT ADDRESS Ms. Debbie Million 600 Dunwich Way Balto., Md. 21221 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 3109 DUE TO, OR AS A CONSEQUENCE OF: (b) Organic Brain Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF: (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 7, 1982, to October 8, 1982, that (I) (we) last saw the deceased alive on October 8, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Eric Bligard | | DEGREE | | 22c. DATE SIGNED Oct 8 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Bligard M.D. | | 22e. ADDRESS 9000 Franklin Square Drive 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | 23b. DATE 10/11/82 | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR OCT 18 1982 | 25b. REGISTRAR'S SIGNATURE John J. Connel |

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 3 8 3 | | | |
|--|--|---|--|---|--|---|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ALVERTA G. VINTON | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10/22/82 | | | | 2b. HOUR 8:10P.M. | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 09 10 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wrapper May Company | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MD | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN Hillendale | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1264 XXXXXX HALSTEAD RD | | 21234 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Harman | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Lebon | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-12-6317 | | 17. INFORMANT ADDRESS Mrs. Margaret J. Tracey Same as #13. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-22-82, 1982, to 10-22-82, 1982, that (I) (we) lost the deceased on 10-22-82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Eugene J. Kelley, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/22/82 | | | | | |
| 22d. PHYSICIAN'S NAME Eugene J. Kelley, M.D. | | | | | | 22e. ADDRESS 7620 York Road Towson Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Oct. 26, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Overlea Balto., Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 26 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Lohr | | | | | |

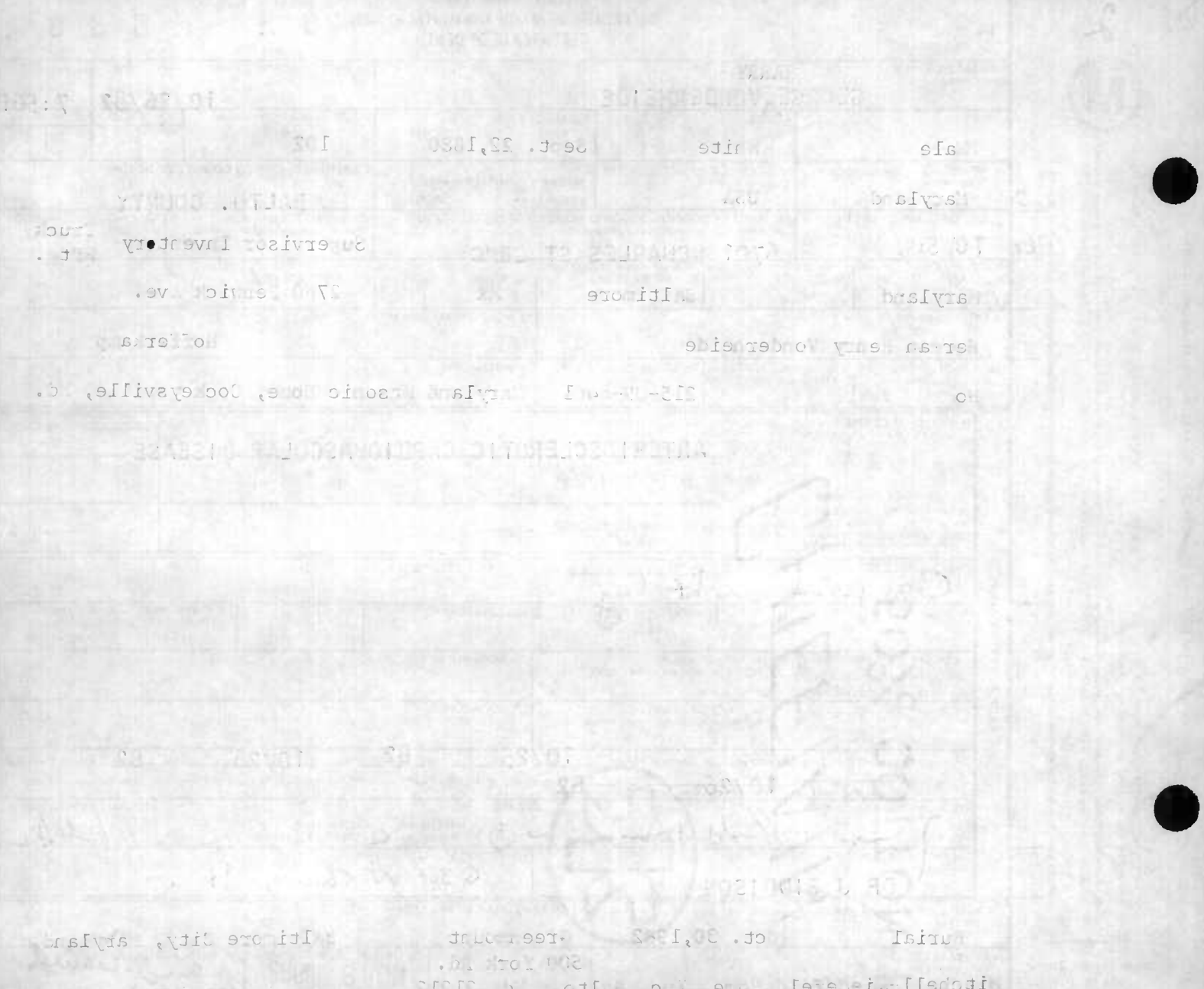
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 2 5 3 8 4 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE VONDERHEIDE | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10/26/82 | | 2b. HOUR 7:50 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1880 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 102 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 NCHARLES ST GBMC | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor Inventory | | 12b. KIND OF BUSINESS OR INDUSTRY Truck Mfg. | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herman Henry Vonderheide | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hofferkamp | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 215-09-6461 | | 17. INFORMANT ADDRESS Maryland Masonic Home, Cockeysville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Gangrene right leg. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/25 , 19 82 , to 10/26 , 19 82 , that (I) (we) lost saw the deceased alive on 10/26 , 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DR J BIDDISON | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/26/82 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Oct. 30, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | 24b. ADDRESS 6500 York Rd. | | 25a. DATE REC'D. BY REGISTRAR NOV 8 1982 | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland | | | | 25b. REGISTRAR'S SIGNATURE John J. [Signature] | | | |



2041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 2 5 3 8 5 | |
|---|--|-------------------------|---|---|---|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LESTER BENJAMIN WAGNER | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 10 24 82 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 2 DAY 20 YEAR 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH Dundalk | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1910 Codd Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | | 12b. KIND OF BUSINESS Trucking | |
| 13a. STATE Maryland | | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1910 Codd Avenue 21222 | | | | |
| 14. FATHER'S NAME FIRST Lester MIDDLE F. LAST Wagner | | | 15. MOTHER'S MAIDEN NAME FIRST Irma MIDDLE F. LAST Hughes | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | | 17. INFORMANT 8414 Sandy Plains Road Balto., MD. 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic malnutrition DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Carcinoma of the larynx | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE J. Crossan O'Donovan | | | TITLE (SPECIFY) Deputy | | | MEDICAL EXAMINER | | | DATE SIGNED 10/24/82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN | | | ADDRESS 2112 Dundalk Ave., Balto., Md. 21222 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/28/82 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill | | | 23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 27 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | |

100% COTTON 1964

WELLS FARGO

100% COTTON 1964

WELLS FARGO

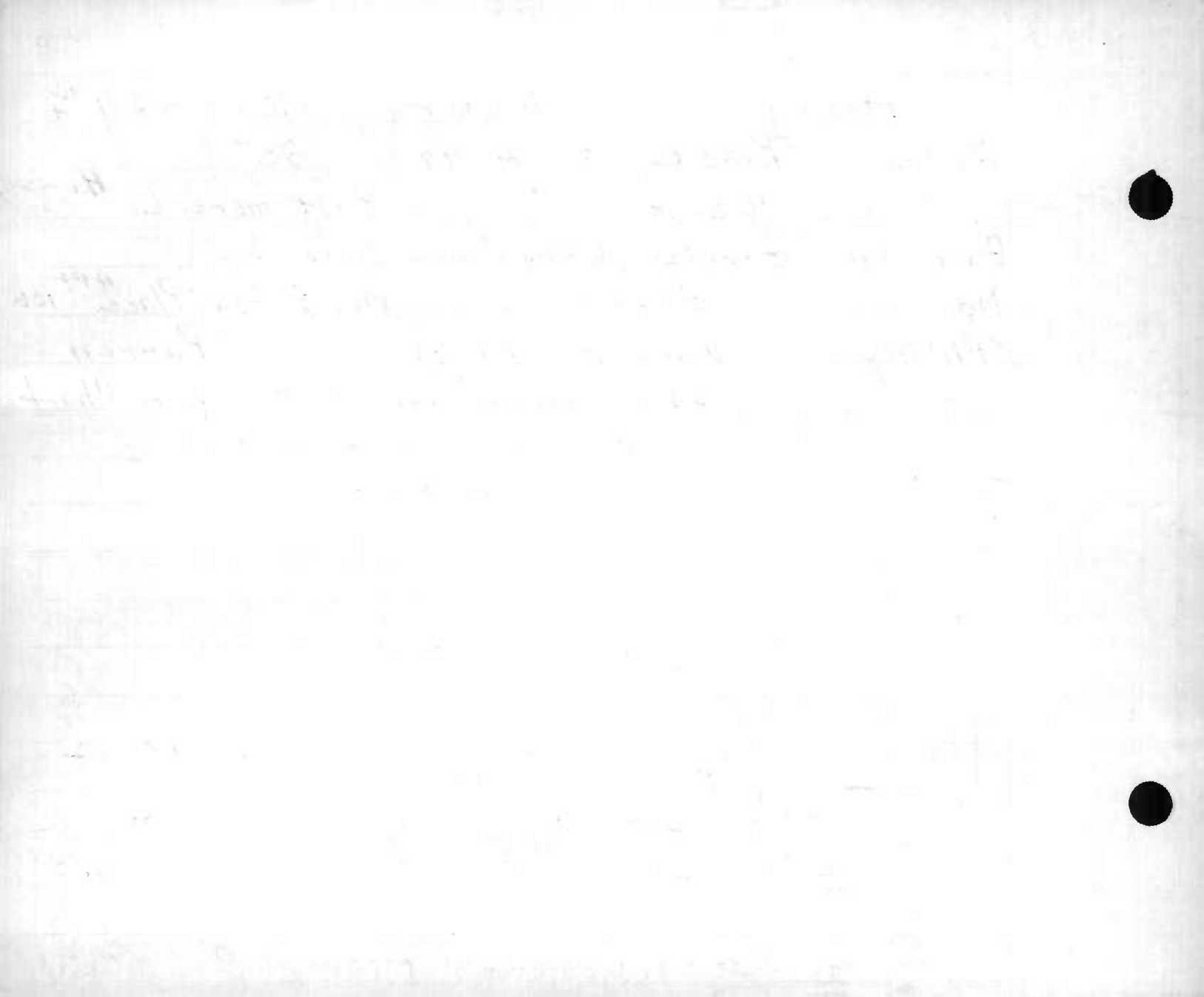
WELLS FARGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 3 8 6 | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Henry | | | MIDDLE Walker | | | LAST Walker | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR 9 30 A.M. | |
| 3. SEX Male | | | 4. RACE Black | | | 5. DATE OF BIRTH MONTH DAY YEAR 3 4 97 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. | | | 10. BARRISON, MD. | | | |
| 10. CITY OR TOWN OF DEATH Garrison | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrison Valley Center | | | 12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) Contractor | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. | | | 13c. COUNTY Baltimore | | | 13d. CITY OF TOWN Baltimore | | | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13f. STREET ADDRESS 1701 Eutaw Place Apt. 106 | | | |
| 14. FATHER'S NAME 14a. FIRST Phillip | | | 14b. MIDDLE Walker | | | 14c. LAST Walker | | | 15. MOTHER'S MAIDEN NAME 15a. FIRST Liza | | | 15b. MIDDLE Parren | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 216-10-8783 | | | 17. INFORMANT Bessie C. Walker | | | 17a. ADDRESS 1701 N. Eutaw St. | | | 17b. Apt. 106 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Probable Myocardial infarction | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) Old age | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 9/29/82 to Oct 16, 1982, that (1) saw the deceased alive on 9/29/82, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (2) (we) did not view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE L Boas MD | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED Oct 18, 82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L Boas MD | | | 22e. ADDRESS 58 Scott Adam Rd Cockeysville Md 21030 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 10/22/82 | | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk- | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | | | | | 25a. DATE REC'D-BY REGISTRAR OCT 20 1982 | | | 25b. REGISTRAR'S SIGNATURE John J. Canine | | | | | | |



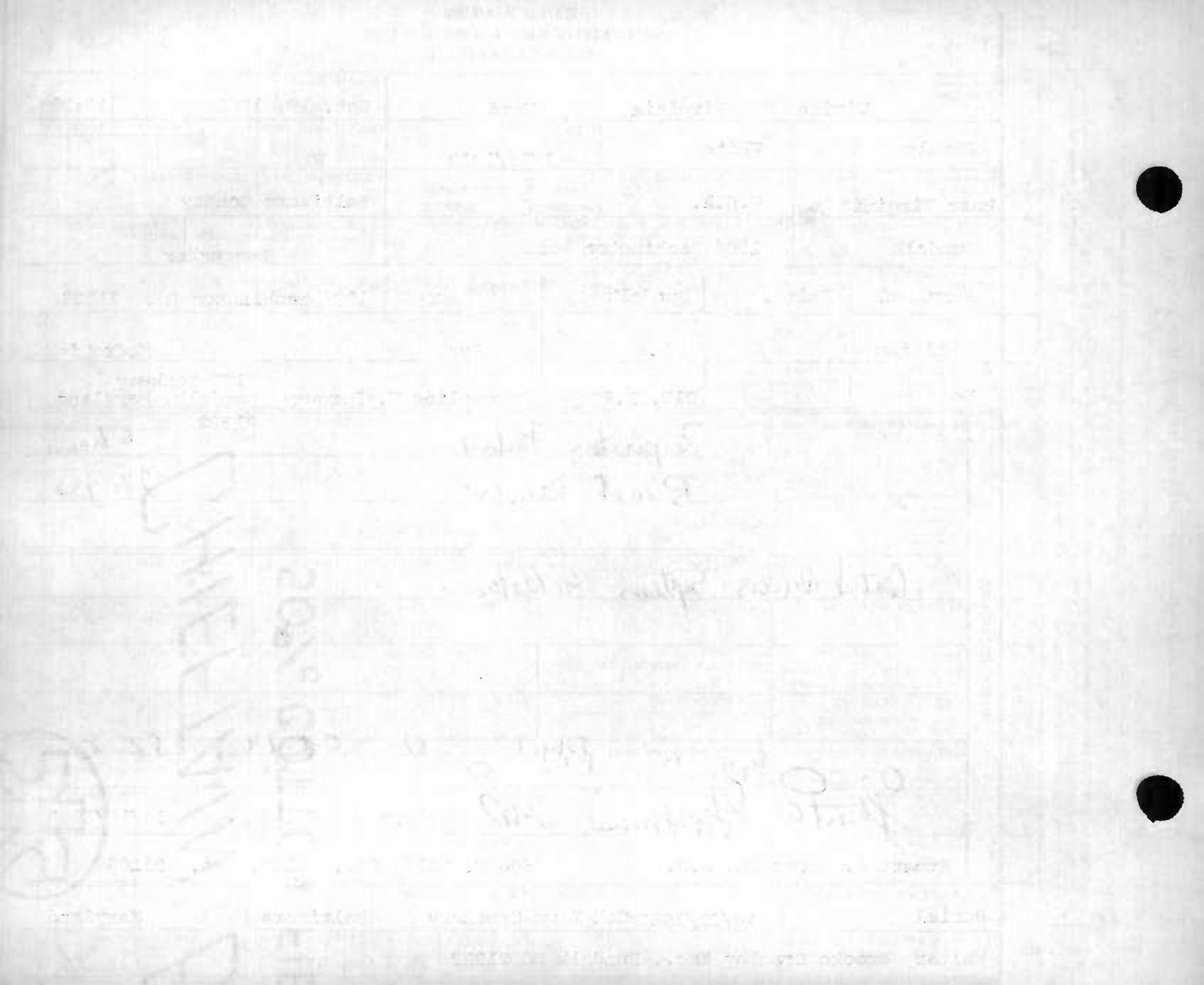
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 2 5 3 8 7 | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vivian Virginia Ward | | | | 2a. DATE OF DEATH MONTH DAY YEAR Oct. 19, 1982 | | 2b. HOUR A M 10:39 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1/15/1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | |
| 10. CITY OR TOWN OF DEATH Dundalk | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1904 Washington Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY BALTO. 13c. CITY OR TOWN Dundalk | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1904 Washington Rd. 21222 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Dice | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elva McCrobie | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 217.22.9909 | | 17. INFORMANT ADDRESS Jacqueline V. Perouty 3100 Yorkway Dundalk, Maryland 21222 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast Cancer</u> 2 1/2 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Central Nervous System Metastases</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Central Nervous System Metastases</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>81</u> , to <u>Oct 19</u> , 19 <u>82</u> , that (II) (we) last saw the deceased alive on <u>Sept 15</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Stuart A. Grossman</u> | | | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/19/1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart A. Grossman, M.D. | | | | 22e. ADDRESS 600 N. Wolfe St., Balto., Md. 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/21/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR Walter Brooks Bradley Inc., Dundalk Md 21222 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 21 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|---------|---|-----------------------------------|
| 1. FOR STATE REGISTRAR | | REG. NO. 82 25388 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ISABEL | | H. | | WARNER | | | | 10 03 82 | | 06:35 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | Cauc. | | July 7 1897 | | 84 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Towson | | St. Joseph's Hospital | | | | | | | | Dog Breeder | Own Bus. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Md. | | Balto. | | Timonium | | | | 228 W. Timonium Rd. 21093 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| John Carol Howard | | | | Margaret Roberts | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | |
| No | | | | 214-01-7920 | | Mrs. Margaret T. Almond | | | Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | |
| (b) MYOCARDIAL INFARCTION | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) / | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION - STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/12/82, to 10/03/82, that (I) (we) lost (we) the deceased (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| A.K. CHOPRA | | M.B.B.S. | | | | | | 10/03/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| A.K. CHOPRA | | | | ST. JOSEPH HOSPITAL 7620 YORK RD. BALTIMORE MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 10-5-82 | | St. James Church Cem. | | Monkton Balto Md | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25. REGISTRAR'S SIGNATURE | | | | | | | |
| Henry W. Jenkins & Sons | | | | John J. Carver | | | | | | | |

1944-1945

1946-1947

1948-1949

1950-1951

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

1972-1973

1974-1975

1976-1977

1978-1979

1980-1981

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 8 9 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR HOUR | | | |
| Marie E. Warner | | | | 12-9-82 10:20 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | |
| Female | | White | | 12-08-01 | | 80 YRS. | |
| 7. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | IF UNDER 1 YEAR | |
| Md. | | U. S. A. | | NEVER MARRIED | | IF UNDER 24 HRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 12a. USUAL OCCUPATION | |
| Randallstown | | Baltimore Co. General Hosp. | | Baltimore County MD. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MD. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | #21201 | |
| Chester | | | | 501 W. Franklin St. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMATION | | ADDRESS | |
| (YES, NO OR UNKNOWN) | | 215-01-4908 | | 3751 Wilkens Ave., Balto., Md. | | 21229 | |
| 18. CAUSE OF DEATH | | 19. IMMEDIATE CAUSE | | 20. DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 5733 | | Cardiorespiratory Arrest. | | Hepatitis with chronic renal failure. | | | |
| 21. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH | | 22. BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | 23. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | |
| OR CONTRIBUTING CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | P.M. 19 | | | | | |
| 21e. PLACE OF INJURY | | 21f. LOCATION | | 21g. DATE OF INJURY | | 21h. DATE OF DEATH | |
| (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | 9-28-82 to 10-9-82 | | 10-8-82 | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| saw the deceased alive on | | Merchant Dupak | | MD | | 10-9-82 | |
| above, (I) (we) (did) (did not) view the body after death. | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE RECEIVED BY REGISTRAR | |
| | | D. P. Merchant | | 3350, Wilkens Ave. MD 21229 | | OCT 18 1982 | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| (SPECIFY) | | 10-11-82 | | Westview Mem. Pk. | | CITY OR TOWN COUNTY STATE | |
| Cremation | | | | | | Balto. Md. | |
| 24. FUNERAL DIRECTOR | | 25. DATE | | 26. SIGNATURE | | 27. SIGNATURE | |
| NAME | | 3512 Frederick Ave. #21229 | | John J. Connelley | | John J. Connelley | |
| Truman Schwalbe | | | | | | | |

Handwritten notes at the top of the page, including a date "11-2-52" and a name "Honorable".

217-02-1808 Mrs. Lucille G. Goodall
217-02-1808

RECEIVED
FEB 11 1953



217-02-1808
FEB 11 1953
217-02-1808

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 3 9 0 | | | |
|---|--|---|--|---|---|---|--|--|---------------|-------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Sarah Helen WEBER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR October 28, 1982 | | | | 2b. HOUR M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 13 1982 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cockeysville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1635 Beaver Brook Lane | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales | | 12b. KIND OF BUSINESS OR INDUSTRY Mercantile | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Cockeysville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1635 Beaver Brook Lane 21030 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George C. Hoffman | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Flora Moran | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 03 4459 | | 17. INFORMANT ADDRESS Lane 21030 Mrs. Jennie M. Mills 1635 Beaver Brook | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Sept 19 82</u> , 19 <u>75</u> , to <u>October 28</u> , 19 <u>82</u> , that (1) (we) lost saw the deceased alive on <u>Sept 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert Stoner</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>10-29-82</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert Stoner | | | | 22e. ADDRESS 714 York Road 21204 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 30 OCT 82 | | 23c. NAME OF CEMETERY OR CREMATORY Grace Methodist Ceme. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Reisterstown, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>John J. Lemmon</u> ADDRESS J. E. Lowell Lemmon Padonia & York Rds. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 29 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Lemmon</u> | | | | | | | |

21

• **QC**

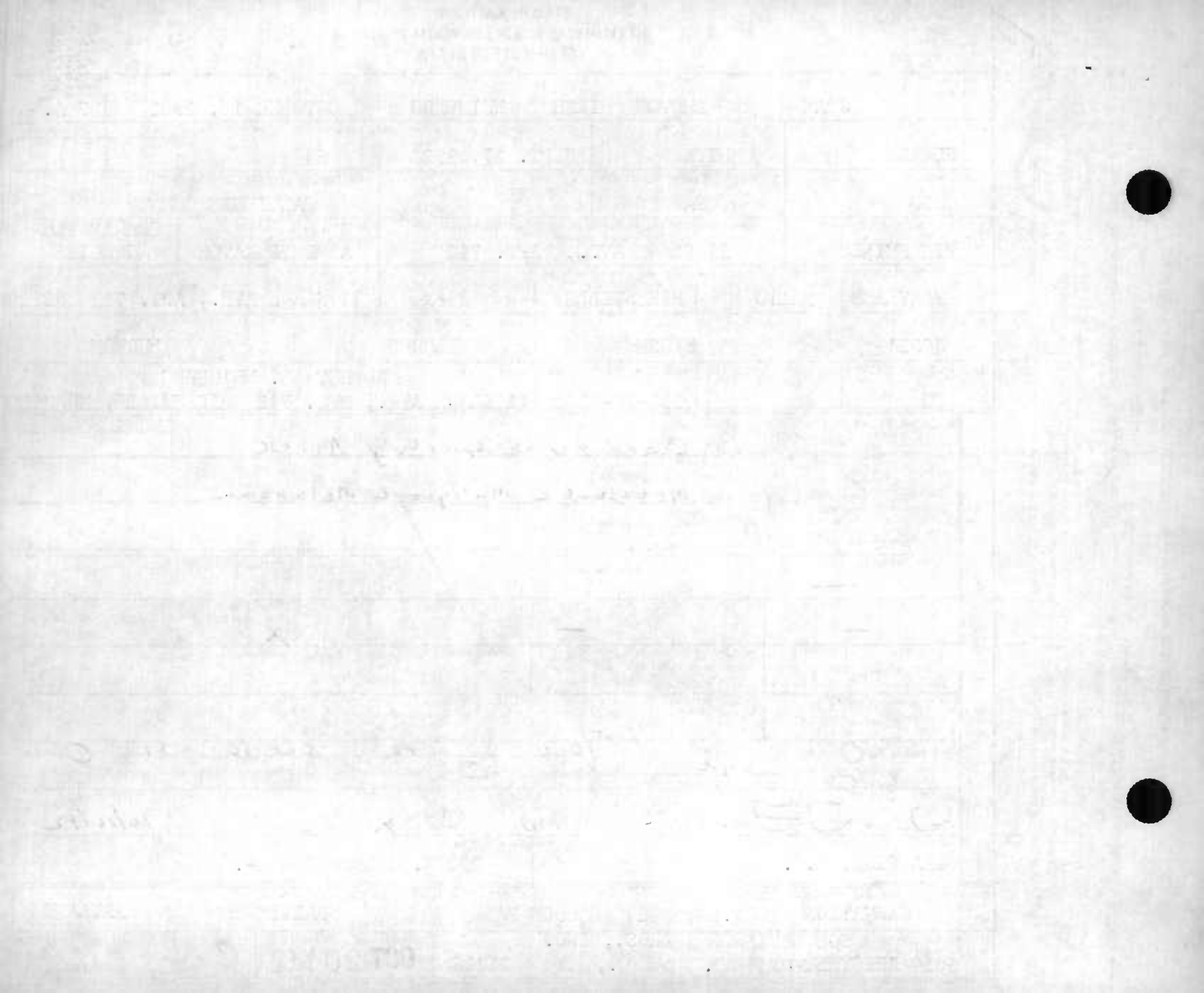
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 2 5 3 9 1 | |
|---|--|--|--|---|--|---|--|--|--------------------------------------|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) JEAN BURTON HIRSH WEINBERG | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 16, 1982 | | | 2b. HOUR 7 A. M. | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR SEPT. 17, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH PIKESVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 SLADE AVE., APT. 712 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADMINISTRATOR | | | 12b. CHARITABLE OR INDUSTRY AGENCIES | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTO 13c. CITY OR TOWN PIKESVILLE | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 11 SLADE AVE., APT. 712 #21208 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSE' HIRSH | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED BURTON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-26-3150 | | 17. INFORMANT ADDRESS ROBERT L. WEINBERG 11 SLADE AVE., APT. 712 PIKESVILLE, MD 21208 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-Respiratory Arrest</u> 1729 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Malignant Melanoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>Sept/Oct</u> , 19 <u>82</u> , to <u>Oct 16</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>Sept</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Ira Fine</u> | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA FINE, M.D. | | | | 22e. ADDRESS 222 W. COLDSRING LA. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE OCT. 18, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | | 23d. LOCATION CITY OR TOWN COUNTY MARYLAND BALTIMORE | | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 20 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Casper</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 9 2

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STEWART GORDON WELDON | | | 2a. DATE OF DEATH MONTH DAY YEAR October 29, 1982 | | 2b. HOUR 1 A. M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR December 8, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County |
| 10. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 302 E. Joppa Road | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker | |
| 12b. KIND OF BUSINESS OR INDUSTRY Real Estate | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Towson | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13e. STREET ADDRESS 302 E. Joppa Road | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Mitchell Weldon | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Chase | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-09-4565 | | 17. INFORMANT ADDRESS Mrs. Margaret Todd 628 Yarmouth Road | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (c) CA - COLON. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1539 MONTHS. YRS. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 23, 19 76 , to OCT 29, 19 82 , that (I) (we) lost saw the deceased alive on OCT 28, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE S. J. Venable | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 10-29-82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. J. Venable, M.D. | | 22e. ADDRESS 7215 York Road | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 11-1-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge | | 23d. LOCATION Dorsey, COUNTY Maryland |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. | | ADDRESS 1050 York Road | | 25a. DATE REC'D. BY REGISTRAR NOV 1 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 9 3 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST CLINTON M. WERNER | | | | MONTH DAY YEAR HOUR 10 16 82 2:54 P.M. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 28, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION GBMC 6701 N. CHARLES ST. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Sup. | | 12b. KIND OF BUSINESS OR INDUSTRY Bendix Corp. | |
| 13a. STATE Md. | | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Owings Mills | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick Werner | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Ludwig | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-03-2766 | | 17. INFORMANT Helen Werner | | 15 Bradbury Road Owings Mills, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5698 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ANASARCA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) SMALL BOWEL PERFORATION PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION 10-11-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SMALL BOWEL PERFORATION | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-1, 19 82, to 10-16, 19 82, that (I) (we) lost saw the deceased alive on 10-16, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE William M. Boggs | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM M. BOGGS, M.D. | | | | 22e. ADDRESS GBMC 6701 N. CHARLES ST., X | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 19, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Carroll, Md. | |
| 24. FUNERAL DIRECTOR H. J. Ehrhardt | | | | 25. RECEIVED BY REGISTRAR OCT 19 1982 John J. Carroll | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

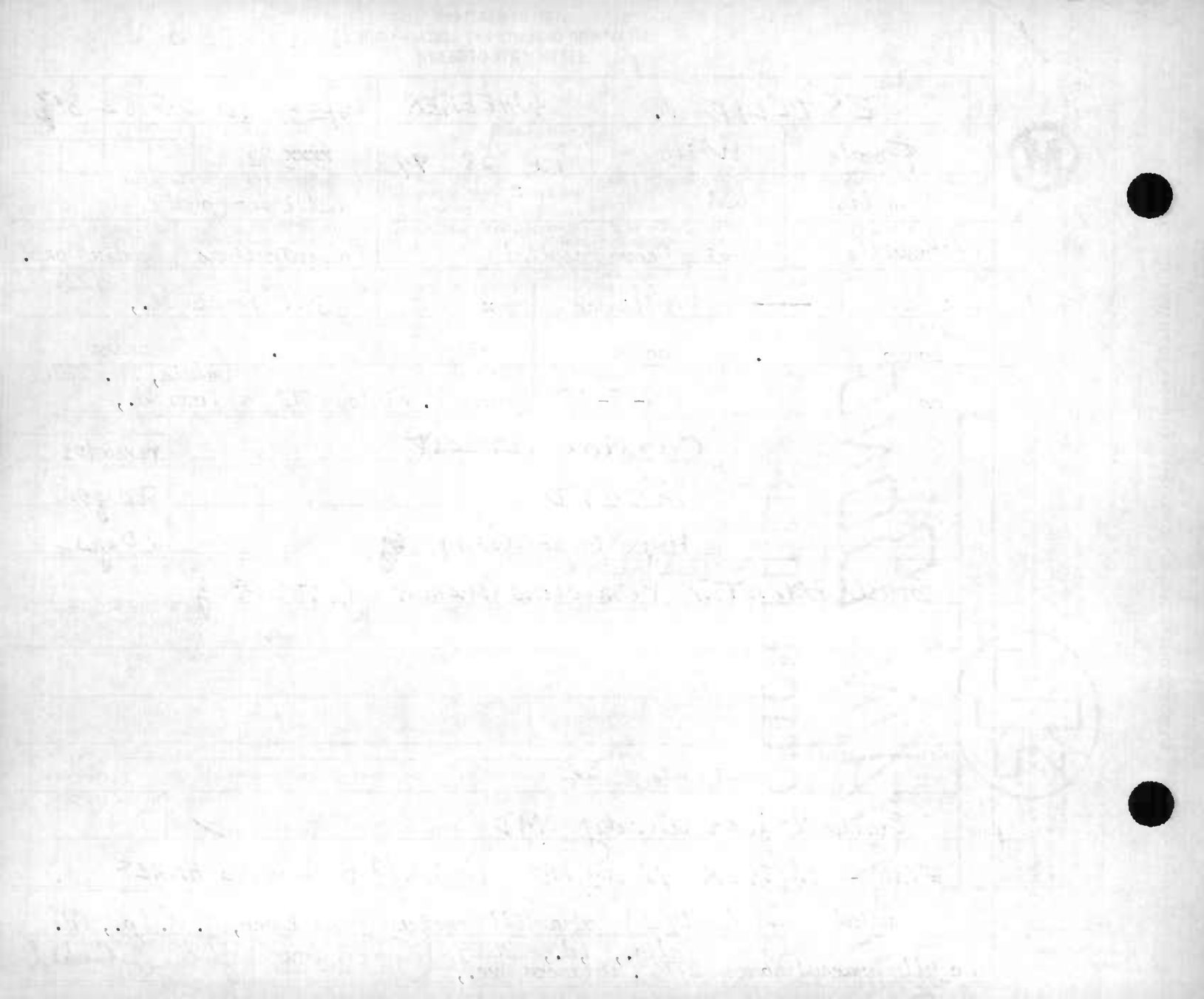
REG. NO.

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|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ESTELLE M. WHEELER | | | 2a. DATE OF DEATH MONTH DAY YEAR 10/25/82 2b. HOUR 8:15 P.M. | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 12 28 99 | 6. AGE (IN YEARS LAST BIRTHDAY) 80 3 82 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN. |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 9. CITIZEN OF WHAT COUNTRY? USA | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 12. CITY OR TOWN OF DEATH Catonsville | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Spring Grove Hospital | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Communications | | 15. KIND OF BUSINESS OR INDUSTRY Bendix Corp. |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland 16b. COUNTY --- 16c. CITY OR TOWN Baltimore | | | 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18. STREET ADDRESS 3911 Fourth St., 21225 |
| 19. FATHER'S NAME FIRST MIDDLE LAST Longo D. Warner | | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy A. Warner | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) | | 22. SOCIAL SECURITY NO. 215-05-6050 | | 23. INFORMANT ADDRESS Belair, Md. 21014 Eugene T. Finley 512 Red Pump Rd., | |
| 24. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Arrest 2449 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 20 yrs. 20 yrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Severe Dementia, Pernicious Anemia, Gastritis | | | | | |
| 25. DATE OF OPERATION | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 33. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 34. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) lost saw the deceased alive on Oct 25, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 35. SIGNATURE Emma McIVER Woody | | 36. DEGREE M.D. | | 37. DATE SIGNED | |
| 38. PHYSICIAN'S NAME (TYPE OR PRINT) EMMA McIVER WOODY MD | | 39. ADDRESS TANES/B-D NURSING HOMES | | | |
| 40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 41. DATE 10/28/1982 | 42. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 43. LOCATION CITY OR TOWN COUNTY STATE Baltimore, A. A. Co., Md. | |
| 44. FUNERAL DIRECTOR NAME McCully Funeral Homes | | 45. ADDRESS Baltimore, Md., 21225 237 E. Patapsco Ave., | | 46. DATE REC'D. BY REGISTRAR OCT 28 1982 | |
| | | 47. REGISTRAR'S SIGNATURE John J. Connel | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

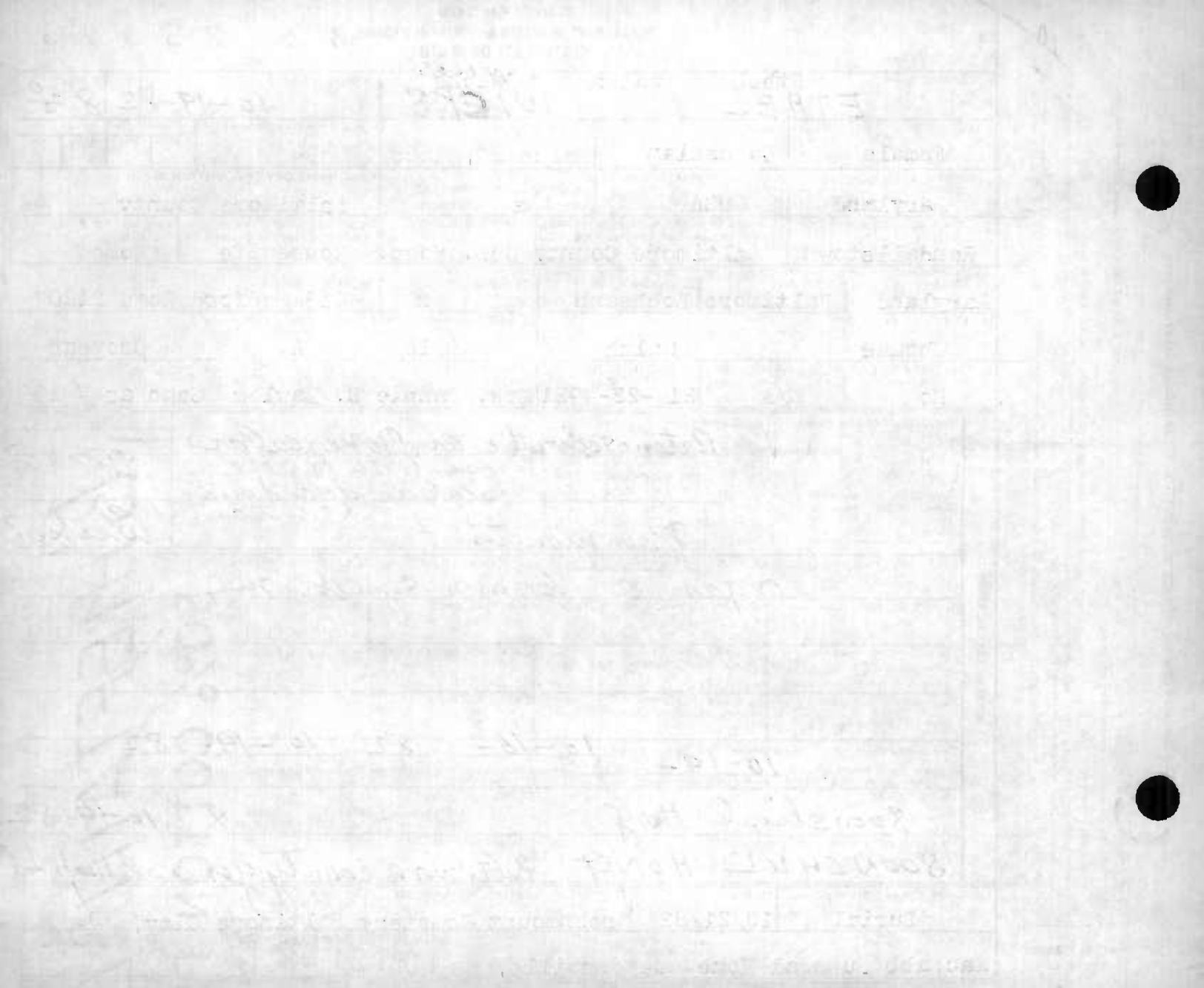


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 2 5 3 9 5 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST Ethel MIDDLE Walsh LAST WICKS ETHEL WICKS | | | | MONTH DAY YEAR HOUR 10-19-82 8:00 A.M. | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR March 25, 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Lochearn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Walsh | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie A. Croyeau | | 13e. STREET ADDRESS 4015 Bedford Road 21207 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Mrs. Nannie C. Lawler Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with severe cerebrovascular accident (contractured) DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia? DUE TO, OR AS A CONSEQUENCE OF (c) organic brain syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4292 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years? Weeks? | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-16-1982 to 10-19-1982 , that (I) (we) lost saw the deceased alive on 10-19-1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Soonchul Hong | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10-19-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOONCHUL HONG | | | | 22e. ADDRESS Baltimore County General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery Baltimore City, MD | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville, MD | | | | 25a. DATE REC'D. BY REGISTRAR OCT 21 1982 | | | |



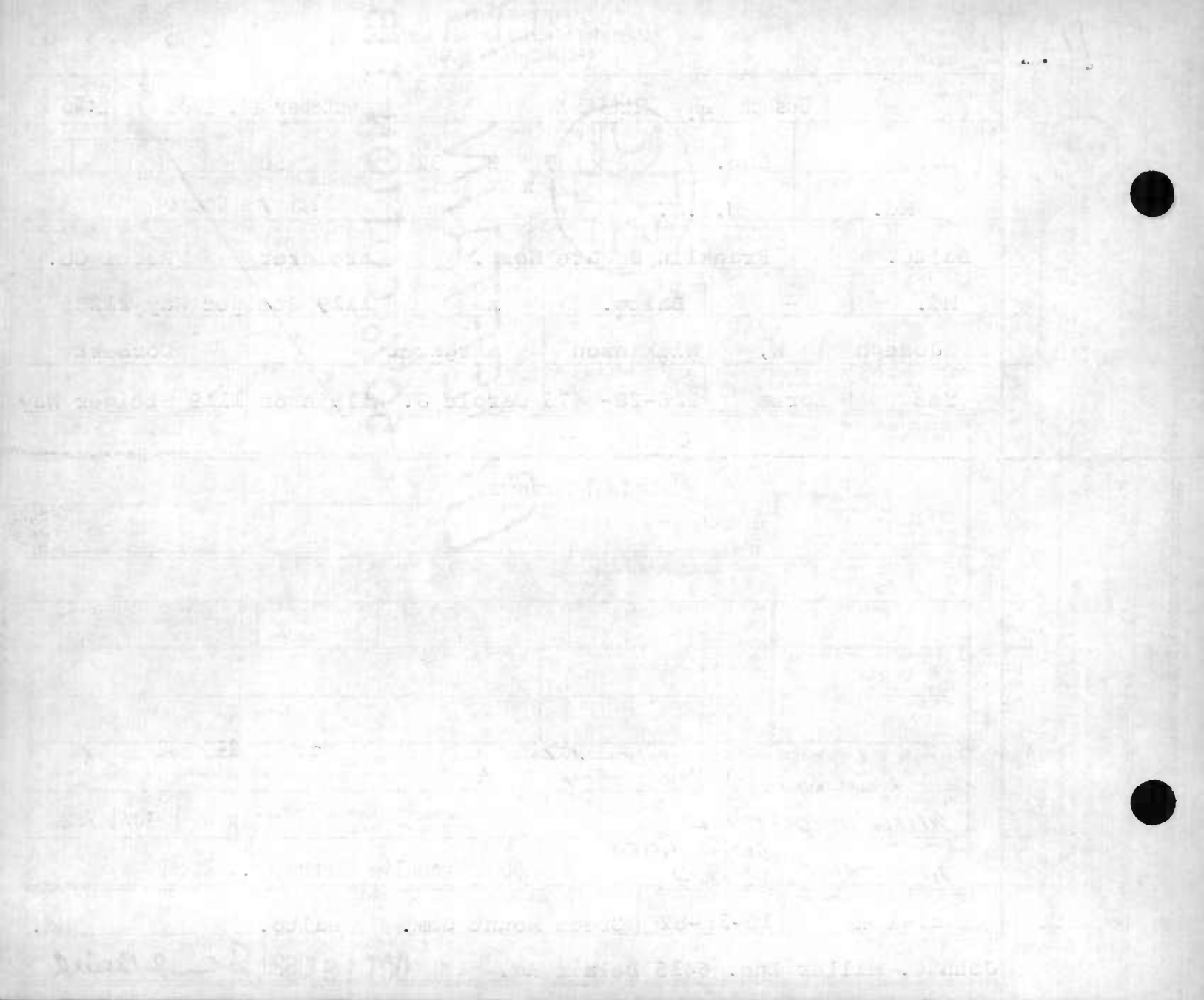
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 3 9 6 | |
|---|--|--|---|---|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph M. WILKINSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR October 14, 1982 | | | 2b. HOUR 2:45 P.M. | | | |
| 3. SEX Male | | 4. RACE Cau. | | 5. DATE OF BIRTH MONTH DAY YEAR 7 2 32 | | 6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY Rocci Co. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. | | 13b. COUNTY - | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1119 Steiger Way 21205 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph W. Wilkinson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Dorbert | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. Korea | | 17. INFORMANT ADDRESS Carole J. Wilkinson 1119 Steiger Way | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4414 Cardiac arrest IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Abdominal aneurysm (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from October 3, 19 82 , to October 14, 19 82 , that (we) last saw the deceased alive on October 14, 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Eileen Shapiro MD | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 10/14/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EILEEN SHAPIRO | | | | | | 22e. ADDRESS 9000 Franklin Square Dr., 21237 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 10-15-82 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc. 6415 Belair Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 19 1982 John J. Canfield | | | | | |



NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR Item 18b Film 574 cn
1- STATE REGISTRAR 12-7-82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 3 9 7
REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) BABY BOY WILLIAMS | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 29 '82 | | 2b. HOUR 2:52P M |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 10 27 '82 | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 2 | | IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, COUNTY MD | | |
| 10. CITY OR TOWN OF DEATH TOWSON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC - 6701 N. CHARLES STREET | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN Balto | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 4419 Marble Hall Rd. Apt 270 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LEROY (NMN) WILLIAMS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSALINE STEPHENSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT ADDRESS 4419 MARBLE HALL ROAD APT. 270 21218 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> 7690 DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE RPS Respiratory Distress Syndrom</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PROABLE CRANIAL HEMORRHAGE</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/27</u> , 19 <u>82</u> , to <u>10/29</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>10/29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>V. Torres, M.D.</u> DEGREE | | | | 22c. DATE SIGNED 10/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIRMA V. TORRES, M.D. | | | | 22e. ADDRESS GBMC - 6701 N. CHARLES STREET 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY GBMC | 23d. LOCATION CITY OR TOWN COUNTY STATE Towson Balto MD | | |
| 24. FUNERAL DIRECTOR NAME <u>Chas. C. Acorn</u> | | | 25a. DATE REC'D. BY REGISTRAR NOV 5 1982 | | |
| | | | 25b. REGISTRAR'S SIGNATURE <u>John G. Carver</u> | | |

1248

(22)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 2 5 3 9 8 | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ADA W WILLIAMS. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10-20-82 | | | |
| 3. SEX Female | | | | 2b. HOUR 8 12 M | | | |
| 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR October 31, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto County MD | |
| 10. CITY OR TOWN OF DEATH TIMONIUM MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS HOSPICE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Talbot | | 13c. CITY OR TOWN Easton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | 13e. STREET ADDRESS Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 156-24-5054A | | 17. INFORMANT Dr. Barbara Hudson | | 17a. ADDRESS 8712 Windsor Mill Rd. Balto. MD. 21207 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: Cerebral Vascular Accident 4860 IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Nakhuda | | DEGREE | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Eddie Nakhuda | | 22e. ADDRESS Stella Maris Hospice | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 10-21-82 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto MD. | |
| 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 21 1982 | | | |
| 24a. NAME 8728 Liberty Road Randallstown, MD. 21133 | | | | 25b. REGISTRAR'S SIGNATURE John J. Givich | | | |

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UNITED STATES OF AMERICA

SECTION 1

SECTION 2

SECTION 3

SECTION 4

SECTION 5

SECTION 6

SECTION 7
20% COIL

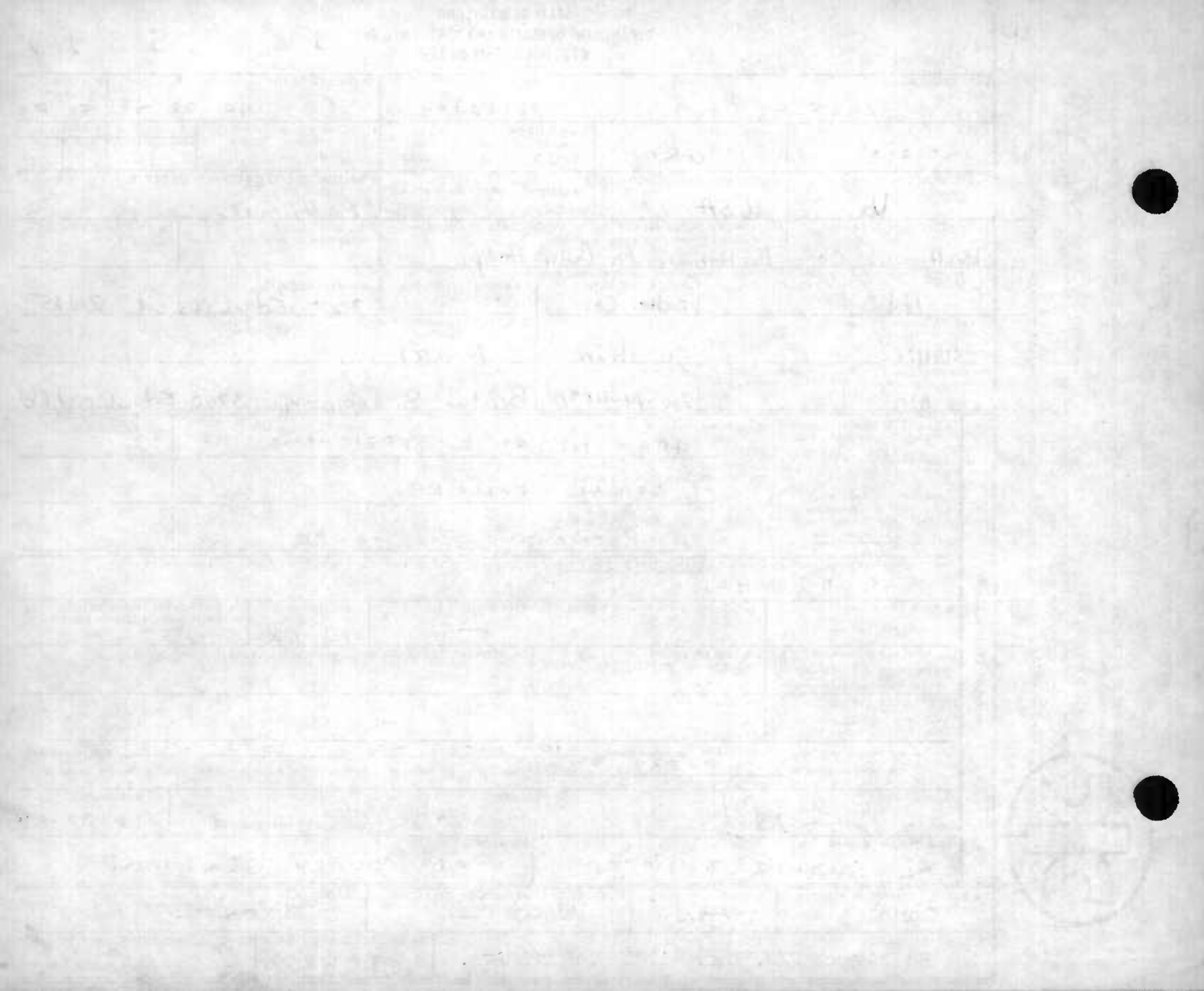


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 3 9 9 |
|---|--|---|--|---|--|--|--|--|-------|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST CHARLES | | MIDDLE | | LAST WILLIAMS, | | 2a. DATE OF DEATH MONTH DAY YEAR 10 22 82 | | 2b. HOUR 5 15 PM |
| 3. SEX MALE | | 4. RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR 02 21 68 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. | | MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore Co. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE MD | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN Baltimore Co. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3700 Edgewood Rd | | 21215 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willie | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Naomi | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-14-4831 | | 17. INFORMANT Beulah B. Robinson | | ADDRESS 3700 Edgewood Rd |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GRAM NEGATIVE SEPTICEMIA 0384 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CH. RENAL FAILURE. (c) SIP. PERMANENT PACEMAKER. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCEND. CHF. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) - | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-14-1982, to 10-22-1982, that (I) (we) last saw the deceased alive on 10-22-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Sudhir D. Patel | | DEGREE | | 22c. DATE SIGNED 10-22-82 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SUDHIR D. PATEL | | 22e. ADDRESS BAL. COUNTY, GEN. HOSP. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem. | | 23d. LOCATION CITY OR TOWN Baltimore, Md. | | COUNTY | STATE | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H. Inc. | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR OCT 26 1982 | | 25b. REGISTRAR'S SIGNATURE Sam J. Conner | | |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEATH CERTIFICATE AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|------------------|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Janice Moses Williams | | | 2a. DATE OF DEATH KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 1 1982 | | 2b. HOUR M 12:50 |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 10 26 44 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 37 YRS. | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 1 1982 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County | | 10. CITY OR TOWN OF DEATH Dundalk | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1784 Merritt Blvd | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY BALTIMORE | | 13c. STREET ADDRESS 6211 Northwood Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James L. Moses | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Savie Peacock | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS Va, 22180 Vernon Moses 442 Nutley St. N.W. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9650 IMMEDIATE CAUSE (a) Multiple gunshot wounds of head Weapon: Handgun (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:10AM 10/1/82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) sub shop Flettis, | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1784 Merritt Blvd, Dundalk, Balto Co., MD | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Hormez R. Guard, M.D. | | TITLE (SPECIFY) M.D. Assistant | | DATE SIGNED 10/1/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY Greenleaf Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Goldsboro N.C. | | 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue | | | |
| 25. DATE REC'D. BY REGISTRAR OCT 4 1982 | | REGISTRAR'S SIGNATURE John J. Carver | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 2 5 4 0 1 | |
|--|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Michael Willis | | 2a. DATE OF DEATH MONTH DAY YEAR Oct. 23 1982 | | 2b. HOUR 11 ¹⁵ PM | |
| 3 SEX male | 4 RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 10 3 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | |
| 10. CITY OR TOWN OF DEATH Reisterstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bent Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE md. | | 13b. COUNTY Baltimore | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 228 Patterson Park Ave 21231 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unkn | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkn | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 216-09-0270 | | 17. INFORMANT ADDRESS M. Held Landlady Tel 592-9666 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Atherosclerotic CV Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Parkinsonism DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of Prostate APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years Years Years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-13 1977 to 10-23 1982, that (I) (we) lost the deceased alive on 10-23 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE O.E. Williams M.D. | | 22c. DATE SIGNED 10-23-82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) O.E. Williams M.D. | |
| 22e. ADDRESS 11904 Reisterstown Rd Reisterstown MD 21136 | | 22f. PHYSICIAN'S NAME (TYPE OR PRINT) O.E. Williams M.D. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Landsdown, Md. | | 23e. DATE REC'D. BY REGISTRAR OCT 29 1982 | | | |
| 24. FUNERAL DIRECTOR NAME March Funeral Home | | 24b. ADDRESS 1101 East North Ave | | 24c. REGISTRAR'S SIGNATURE John J. Conner | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|--|--|------------------------------|--|--|
| 8 2 2 5 4 0 2 CERTIFICATE OF DEATH | | | | | | | | | |
| FOR 1 - STATE REGISTRAR | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JOHN HENRY WINDER | | | | | 2a. DATE OF DEATH OCTOBER 25, 1982 | | 2b. HOUR 4:00 A.M. | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH FEBRUARY 12, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH FORT HOWARD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WEIGHT MASTER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2005 NORTHEAST AVENUE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL WINDER | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VICTORIA SCOTT | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT CLINICAL RECORDS, VAMC, FORT HOWARD, MD | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC OBSTRUCTIVE AND RESTRICTIVE PULMONARY DISEASE (c) CHRONIC | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ANKYLOSING SPONDYLITIS, S/P TRACHEOSTOMY, Hx OF HYPERTENSION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 7, 1982 , to OCTOBER 25, 1982 , that (I) (we) lost saw the deceased alive on OCTOBER 25, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Vadhana C. Claud</i> MD | | | | | DEGREE MD | | | 22c. DATE SIGNED 10-25-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VADHANA CLAUD, M.D. | | | | | 22e. ADDRESS VA MEDICAL CENTER, FORT HOWARD, MD 21052 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Arbutus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Law Funeral Home 4611 Park Heights Ave. | | | | | 25a. DATE REC'D BY REGISTRAR OCT 27 1982 | | | | |

1970-01-06

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
JANUARY 12, 1970
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows]

[Illegible text follows]

Very truly yours,
[Illegible Signature]
Special Agent in Charge

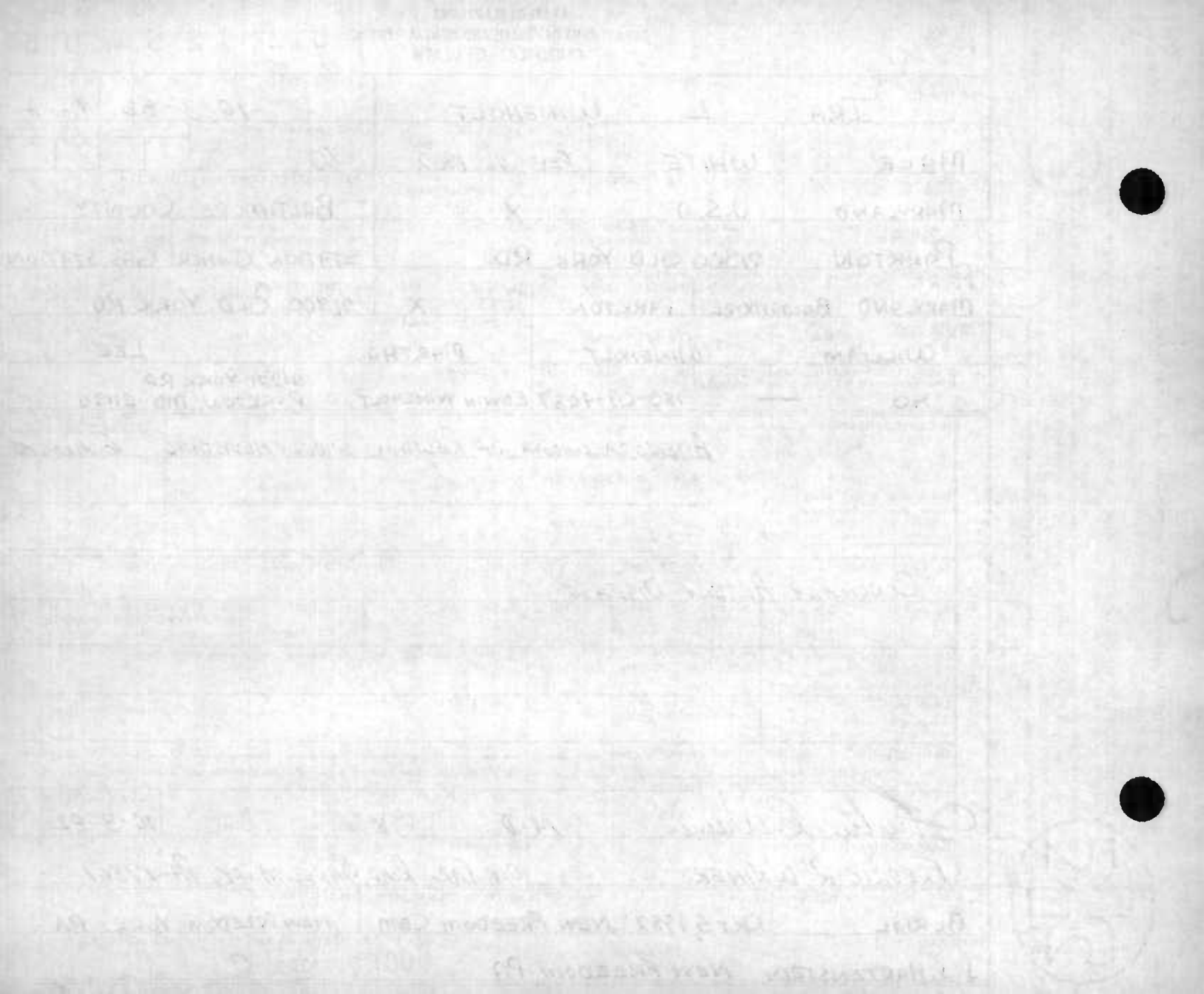
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 5 4 0 3 REG. NO. | | | |
|---|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| IRA | | L. | | WINEHOLT | | 10-3-82 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | |
| MALE | | WHITE | | FEB. 26, 1902 | | 80 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | U.S.A. | | | | BALTIMORE COUNTY MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| PARKTON | | 21300 OLD YORK RD. | | STATION OWNER | | GAS STATION | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13e. STREET ADDRESS | |
| MARYLAND | | BALTIMORE | | PARKTON | | 21300 OLD YORK RD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| WILLIAM WINEHOLT | | | | MARTHA LEE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | |
| NO | | | | 180-09-9087 | | | |
| 17. INFORMANT ADDRESS | | | | 21221 YORK RD PARKTON, MD 21120 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1541 IMMEDIATE CAUSE (a) ADENOCARCINOMA OF RECTUM - WIDELY METASTATIC DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CORONARY ARTERY DISEASE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE FREDRIC R. WEINER | | | | DEGREE M.D. | | 22c. DATE SIGNED 10-3-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDRIC R. WEINER | | | | 22e. ADDRESS OLD FARM ROAD, SHREWSBURY, PA. 17861 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | OCT 5, 1982 | | NEW FREEDOM CEM. | | NEW FREEDOM YORK PA | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| J.J. HARTENSTEIN NEW FREEDOM, PA | | | | OCT 7 1982 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-330-3300.

MEDICAL CERTIFICATION

| FOR 1 - STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 5 4 0 4 REG. NO. | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lingard John Winkler sr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR Oct- 26 1982 | | | | 2b. HOUR 5 55 M | | | |
| 3 SEX M | | 4 RACE W | | 5 DATE OF BIRTH MONTH DAY YEAR MARCH 12 1919 | | 6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | 7a. UNDER 1 YEAR MONTHS DAYS | | 7b. UNDER 24 HRS. HOURS MIN. | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Co. | | 7d. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. Md. MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Perry Hall | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4714 Joppa Rd. Perry Hall, Md. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operating Eng. | | 12b. KIND OF BUSINESS OR INDUSTRY Union Local 37 | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. CITY Baltimore | | 13c. CITY OR TOWN Perry Hall | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4714 Joppa Rd. Perry Hall, Md. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Joseph J. Winkler | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Zimmerer | | | | | | | |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. 1942-1945 | | 17 INFORMANT Mrs. Grace E. Winkler, 4714 Joppa Rd. 21128 | | | | ADDRESS Perry Hall, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Lung | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. | |
| 1629 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 19 74 to Oct 19 82 , that (1) (we) last saw the deceased alive on Oct 21 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE William A. Tyson | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 10-26-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. A. Tyson | | | | 22e. ADDRESS Box 158 Kingsville Md. 21067 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10-30-1982 | | 23c. NAME OF CEMETERY OR CREMATORY St. Josephs R. C. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pullerton Baltimore Md. | | | |
| 24 FUNERAL DIRECTOR NAME E.F. Lassah ADDRESS 11750 Belair Rd. Kingsville, Md. 21087 | | | | | | 25a. DATE REC'D. BY REGISTRAR NOV 1 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

1. The first part of the document is a list of names and addresses.

2. The second part of the document is a list of names and addresses.

3. The third part of the document is a list of names and addresses.

4. The fourth part of the document is a list of names and addresses.

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10. The tenth part of the document is a list of names and addresses.

11. The eleventh part of the document is a list of names and addresses.

12. The twelfth part of the document is a list of names and addresses.

13. The thirteenth part of the document is a list of names and addresses.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND | | | | | | | | | | | |
|---|---------|------------------|--|------------------|------------------|--|--|--|---|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| REG. NO. 25405 | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| STELLA CECELIA WIRT | | | | | | 10 22 1982 | | | 0330 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 24 YRS. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| F. | C. | 02 13 '88 | 64 YRS. | | | 10 22 1982 | | | 1245 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | | | USA | | | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 21224 Baltimore City Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | 8021 E. Baltimore St. #21224 | | | Assembly | | | Bendix & Suburban Plastic | | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | BALTO | | | Baltimore | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | |
| Stephen ? | | | Colombeski | | | Unknown | | | # | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: | | | 19. DATE OF OPERATION | | | 20. AUTOPSY? | | |
| Mrs. Janice Hailey | | | 338 Finn Road 18074 Perkiomenville, Pa | | | 4310 | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| | | | IMMEDIATE CAUSE (a) Acute intracerebral hemorrhage | | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| | | | (b) | | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| | | | (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| Chronic alcoholism | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | 21d. INJURY OCCURRED | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| | | | P.M. 19 | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | |
| | | | | | | | | | 21f. LOCATION | | |
| | | | | | | | | | CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TIME (SPECIFY) | | | DATE SIGNED | | | | | |
| J. Crossan O'Donovan | | | Deputy | | | 10/22/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | |
| J. CROSSAN O'DONOVAN | | | 2112 Dundalk Ave., Balb, Md. 21222 | | | Burial | | | 10/25/82 | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| Walter Dabrowski | | | 1005 Dundalk Ave., 21224 | | | OCT 26 1982 | | | St. Stanislaus | | |
| | | | | | | | | | Baltimore Md. | | |

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W. H. C. 11-11-64

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Maryland USA

Baltimore 8021 E. Baltimore St. Baltimore Assembly

Maryland Baltimore 8021 E. Baltimore St. Baltimore Assembly

Stephen Colobinski

Mrs. Janice Bailey
358 River Road
18074
Pottsville, Pa.

10/22/82



Bureau 10/22/82 St. Louis, Mo.

after review 1005 Lincoln Ave., St. Louis, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified if any.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 4 0 6

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MILDRED A. WOJCIK | | | 2a. DATE OF DEATH MONTH DAY YEAR OCT 29 1982 | | | 2b. HOUR M | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DEC 4 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | |
| 12. CITY OR TOWN OF DEATH LUTHERVILLE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 214 MEADOWVALE ROAD | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. GOVT. | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN LUTHERVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 21093 214 MEADOWVALE RD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM KLEMER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE IDA REMESCH | | | 16. ADDRESS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. 330-20-2335 | | | 17. INFORMANT FAMILY RECORDS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic colon Cancer to pelvis 1991 DUE TO, OR AS A CONSEQUENCE OF (b) many sites metastatic DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>82</u> , to <u>Oct</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Oct 14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Ant</u> <u>Serpick</u> <u>M.D.</u> | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/1/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR A. SERPICK, M.D. | | | 22e. ADDRESS 2360 W. JOPPA ROAD LUTHERVILLE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE NOV. 3, '82 | | 23c. NAME OF CEMETERY OR CREMATORY MEMORIAL GARDENS DULANEY VALLEY | | 23d. LOCATION CITY OR TOWN COUNTY STATE COCKEYSVILLE BALTO. MD. | | | | |
| 24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF CHIMES | | | ADDRESS 2325 YORK RD | | | 25a. DATE REC'D. BY REGISTRAR NOV 12 1982 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u> | | |

MEDICAL CERTIFICATION

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Page 4 may be removed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 2 5 4 0 7 | |
|--|--|---|--|--|--|
| EVELYN M. WOLF | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST EVELYN M. WOLF | | 2a. DATE OF DEATH MONTH DAY YEAR 10 30 82 | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 02 21 05 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) DELAWARE | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | |
| 10. CITY OR TOWN OF DEATH ROSSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MANOR CARE ROSSVILLE | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. County MD. | |
| 12a. USUAL OCCUPATION (TYPE OR PRINT) | | 12b. KIND OF BUSINESS OR INDUSTRY | | HOUSEWIFE | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. STREET ADDRESS 3121 KENTUCKY AVE. 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SADLER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? NO | |
| 16b. SOCIAL SECURITY NO. 215030026 | | 17. INFORMANT ADDRESS EILEEN BOWERS 340 ELINORE AVE. 21236 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) Metastatic Cancer Pancreas | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (in this hospital) attended the deceased from 10/20/82 to 10/30/82, that (we) last saw the deceased alive on 10/30/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE M.D. ATTENDING PHYSICIAN | |
| 22c. DATE SIGNED 10/30/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KHIN M. TUN | | 22e. ADDRESS 2110 Pot Spring Road Md 21093 | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 11/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | |
| 23d. LOCATION BALTO. BALTO. MD. | | 24. FUNERAL DIRECTOR J. J. Cook 4210 Belair Rd, 21206 | | 25a. DATE REC'D. BY REGISTRAR NOV 1 1982 | |
| 25b. REGISTRAR'S SIGNATURE John J. Canine | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 4 0 8 REG. NO. | | | |
|---|--|---|--|---|--|--|--|--|--|-------------------------------|--|--|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) Steve C. Wolinski Sr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10 3 82 | | | | 2b. HOUR M | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 3 12 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH ROSEDALE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7924 BERK LANE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boiler MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MARYLAND | | | | 13b. CITY OR TOWN BALTIMORE | | 13c. STREET ADDRESS 7924 BERK LANE 21237 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stanley Wolinski | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Krajevski | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT HELEN Wolinski | | | | ADDRESS 7924 Berk Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest 1890 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC Renal Cell Carcinoma - 3 mos - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/29/82, to 10/3/82, that (I) (we) last saw the deceased alive on 9/29/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (we) did not view the body after death. | | | | | | | | | | | | | |
| 22a. SIGNATURE JRA. E. HANSMAN | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 10/4/82 | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS 7611 Park Heights Ave - Balt MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 6, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Crownsville Veterans | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS CUNCH Rosedale Funeral Home 1211 Chesapeake | | | | 25a. DATE REC'D. BY REGISTRAR OCT 5 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Carlick | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25409 | |
|--|---------------------|--|---|---|--|--|---|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lurty G. Wood | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 7 1982 | | 2b. HOUR M | | | |
| 1. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 5/18/34 | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 48 | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 7 1982 | | 2d. HOUR a. 5:45 m. M | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH WHITE MARSH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10741 Pulaski Highway | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) EQUIP. OPERATOR | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE MD. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN WHITE MARSH | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 11026 BIRD RIVER RD 21162 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BERNARD WOOD | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CYNTHIA THURSTON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | (IF YES, GIVE WAR OR DATES) KOREA | | 16b. SOCIAL SECURITY NO. 22536 9505 | | 17. INFORMANT ADDRESS LUCILLE WOOD A BOVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9650 Gunshot wounds of Head (Handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY (approx.) HOUR A.M. MONTH DAY YEAR 5:30xx 10 7 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Bar | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10741 Pulaski Highway, Baltimore Co., Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 10-7-82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME J.G. CONNELLY | | ADDRESS 300 MA... | | 25a. DATE REC'D. BY REGISTRAR OCT 13 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Connelly</i> | | | | | |

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 1, 1902

100



ALBANY: J.B. CONVERSE, STATE PRINTER
1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is to be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 2 2 5 4 1 0 | |
|---|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Eugene Collins WOODWARD | | | 2a. DATE OF DEATH MONTH DAY YEAR October 19, 1982 | | 2b. HOUR 3:23 PM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 7, 1908 | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD. | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clergyman | 12b. KIND OF BUSINESS OR INDUSTRY U. Meth. Church | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Glyndon | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 107 A Central Ave. 21071 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert Eugene Woodward | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Collins | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-34-6297 | 17. INFORMANT Ann S. Woodward, Glyndon, MD 21071 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Years | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-31- 19 62 , to 10-19 19 82 , that (I) (we) lost saw the deceased alive on 10-15 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE C.E. McWilliams | | DEGREE MD | | 22c. DATE SIGNED 10-21-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.E. McWilliams | | 22e. ADDRESS 4904 Reisterstown Rd. Reisterstown Md. 21136 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Oct. 22, 1982 | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR H.G. Eckhardt | | ADDRESS Owings Mille, Md. | | 25a. DATE REC'D. BY REGISTRAR OCT 25 1982 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25411 | |
|---|------------------|---|--|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gertrude Woolford | | | | | | | | | | 2a. DATE OF DEATH KNOWN ESTIMATED 10 19 82 | |
| 3. SEX female | 4. RACE Black | 5. DATE OF BIRTH 12 2 04 | 6. AGE (IN YEARS) 78 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD 10 19 82 | | 2d. HOUR 3:15 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County | | PM | | | |
| 10. CITY OR TOWN OF DEATH Randallstown | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hsp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 10380 Painted Cup 21044 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Rev. Isaac Mitchell | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Washington | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-20-6622 | | 17. INFORMANT ADDRESS Llewellyn Woolford 10380 Painted Cup | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolism</u> 8809 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Leg Vein Thromboses</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Fracture Femor</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9/8/82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell on stairs at home | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10380 Painted Cup Columbia How. Co., Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>H. R. Guard</i> | | | TITLE (SPECIFY) M.D. Assistant | | | MEDICAL EXAMINER | | DATE SIGNED 10/20/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, MD | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 10/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. MNorth Avenue | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 21 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Coker</i> | | | | |

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 4 1 2 | | | |
|---|--|---|--|--|--|---|--|--|---------------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) OSCAR ROY WORTMAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10/18/1982 | | | | 2b. HOUR 12:25^{AM} | | | | |
| 3 SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 8/7/1893 | | 6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 0 0 | | IF UNDER 74 HRS. HOURS MIN. 0 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD | | | | | | | |
| 10 CITY OR TOWN OF DEATH DUNDALK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HERITAGE NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY BUILDING CONTRACTOR | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN DUNDALK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7001 DUNHILL ROAD 21222 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES WORTMAN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA THOMPSON | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. W.W.1 215.18.9552 | | 17 INFORMANT WILLIAM W. WORTMAN | | ADDRESS 3018 DUNGLOW RD. DUNDALK, MARYLAND 21222 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure acute + chronic 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Obstructive Airway Disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18 19 76 to 1/17 19 82 that (I) (we) lost saw the deceased alive on 1/16/82 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Theo C Patterson | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 10/18/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THEO. C PATTERSON | | | | 22e. ADDRESS 3427 Dundalk ave 21222 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 10/20/1982 | | 23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 18 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | | | | | | |

Handwritten text, possibly a signature or name, located in the upper middle section of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy of the report filed with this certificate.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 5 4 1 3

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM E. YINGLING, SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR October 5, 1982 | | 2b. HOUR 8:17a M |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR 12 24 98 | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) shipfitter | 12b. KIND OF BUSINESS OR INDUSTRY Bethel Steel | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2015 E. Pratt Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William H Yingling | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Zahn | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | |
| 16b. SOCIAL SECURITY NO. 216 03 1992 A | | 17. INFORMANT ADDRESS Larry Byers 4610 Ballygar Rd 21236 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sudden Gastrointestinal Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Diffuse Transitional Cell Carcinoma of Bladder | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Uremia | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 1, 1982, to October 5, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on October 5, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Louis C. Breschi | | DEGREE M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10-5-82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis C. Breschi | | 22e. ADDRESS 9101 Franklin Square Drive 21237 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 10/8/82 | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | 24. FUNERAL DIRECTOR NAME Walter Pabrowski ADDRESS 1005 DUNDALK AVE | |
| 25a. DATE REC'D. BY REGISTRAR OCT 8 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Conner | | | |

Headwinds: 10-15 mph

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|--|--|--|-------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 2 5 4 1 4 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST HOWARD WALTER YOUNG | | | | | MONTH DAY YEAR HOUR 10 19 82 12:15A M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | WHITE | | MONTH DAY YEAR 8 15 07 | | 75 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| FORT HOWARD | | V. A. MEDICAL CENTER | | | | Stationery Engineers | | AMERICAN BREWING | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE ADDRESS) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND BALTIMORE Rosedale | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Young | | | | | 15. MOTHER'S MAIDEN NAME FIRST LAST Leona Bohlen | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW I | | | | | 16b. SOCIAL SECURITY NO. 705 12 2977 | | 17. INFORMANT ADDRESS 21221 | | |
| | | | | | Clarence Young, 309 Mac Ave. (Son) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 4960 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC RENAL FAILURE; PERIPHERAL VASCULAR DISEASE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/23 , 19 82 , to 10/19 , 19 82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/19 , 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> DEGREE M.D. | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 10/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. V. J. VERGHESE, M.D. | | | | | 22e. ADDRESS V. A. MEDICAL CENTER, FORT HOWARD, MD 21052 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 10/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Garden | | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Middle River, Balt. Co. | | |
| 24. FUNERAL DIRECTOR <i>[Signature]</i> Bruzdinski Funeral Home PA 1407 Old Eastern Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 20 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |

10 19 82 12:12A

YOUNG

WALTER

HOWARD

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WHITE

MALE

WASHINGTON COUNTY

U.S.A.

WASHINGTON

Washington County

V. A. MEDICAL CENTER

PORT HOWARD

1015 GARDEN AVENUE

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V. A. MEDICAL CENTER, PORT HOWARD, MD 21082

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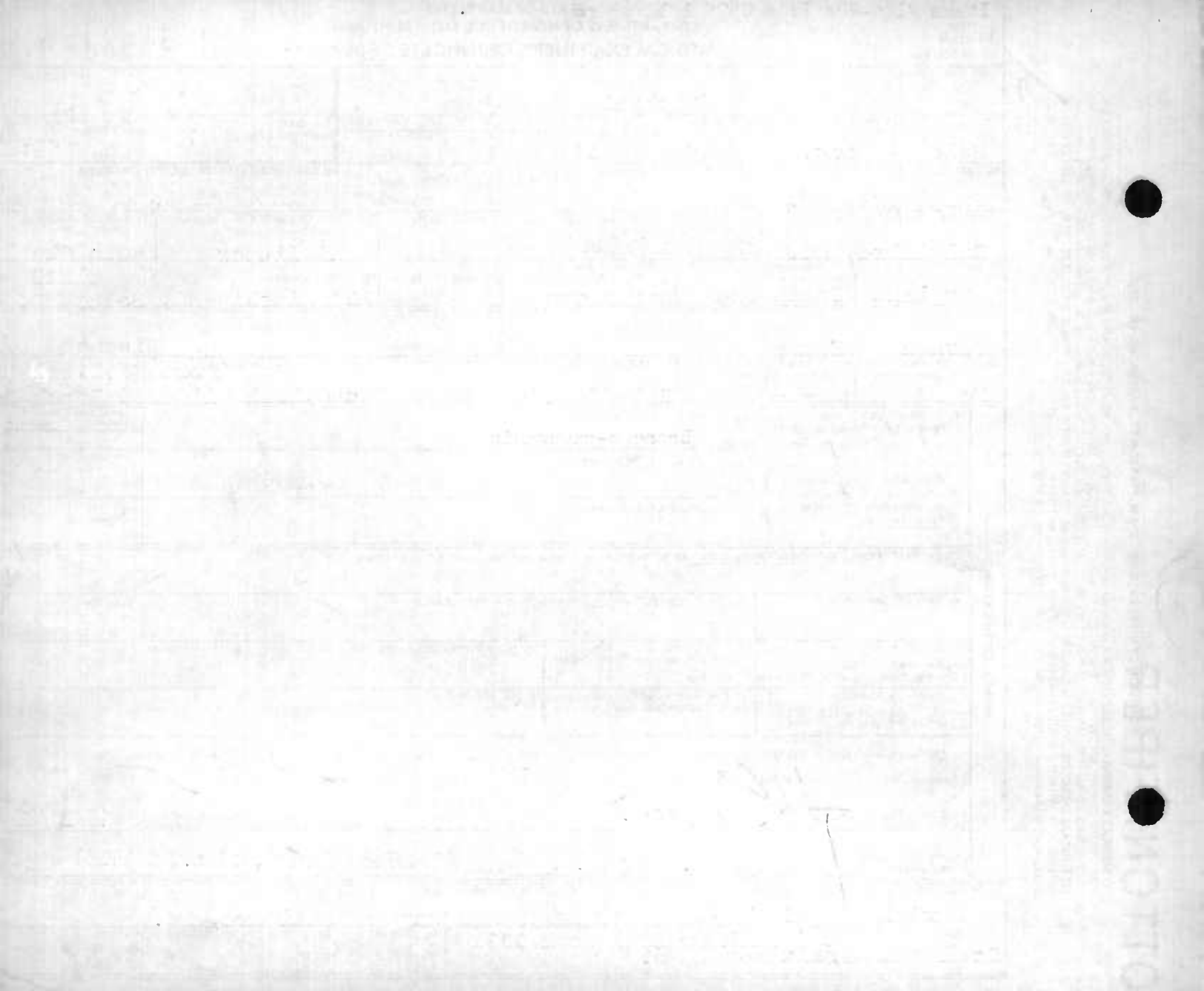
Items #10a-22a Film G575 1/12/83 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 25415

| | | | | | | | | |
|--|-------------------------|---|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Vernon Michael Young | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 18 82 | | | 2b. HOUR M 12:20 | | |
| 3. SEX Male | 4. RACE Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR 3/21/48 | 6. AGE (IN YEARS) LAST BIRTHDAY 34 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 20 82 | 7d. HOUR M 12:20 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County | | |
| 10. CITY OR TOWN OF DEATH Baltimore, Md. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 130 Kinship Road | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipfitter | | 12b. KIND OF BUSINESS OR INDUSTRY Beth Steel | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 21222 130 Kinship Rd, Balto, MD. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Vernon Young | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Wiseman | | | 16. ADDRESS Baltimore, Md. 21221 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - | | 17. INFORMANT Vernon Young, 1321 Wildwood Beach Rd | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 4850 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Hormez R. Guard | | TITLE (SPECIFY) Assistant | | | MEDICAL EXAMINER | | DATE SIGNED 10/20/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | |
| 24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, 3331 Brehm Lane Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 22 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | XC 19832103 | | 8 2 2 5 4 1 6 REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST MIDDLE LAST MARION (Zaleski) ZALEWSKI | | 2a. DATE OF DEATH MONTH DAY YEAR 10 13 82 | | 2b. HOUR 11:52 PM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 3 15 95 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH FORT HOWARD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY Tavern Owner | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1736 GOUGH STREET 21231 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PAUL ZALEWSKI | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW I | | | | 16b. SOCIAL SECURITY NO. 214 16 8539 | | 17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE DUE TO, OR AS A CONSEQUENCE OF (b) EXPIRATION PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) TRACHEOSTOMY APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HOURS 1 DAY | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: S/P Rx OF OSTEOMYELITIS; MULTIPLE DECUBITUS ULCERS; CHRONIC BED RIDDEN STATE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 9/20 19 82, to 10/13 19 82, that (we) lost saw the deceased alive on 10/13 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE DEGREE 22c. DATE SIGNED 10/14/82 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KURT RAAB, M. D. V. A. MEDICAL CENTER, FORT HOWARD, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR Wm. Fialkowski 2007 Eastern Avenue 21231 | | | | 25a. DATE REC'D BY REGISTRAR OCT 15 1982 | | 25b. REGISTRAR'S SIGNATURE | | | |

NO 1232103

10 13 05 11:21

RECEIVED (10/13/05) 11:21

NAME: WIFE 3 12 05 07

FOUNDER: F.A.A. 12 05 07

PORT: HOWARD 12 05 07

RECEIVED: 12 05 07

NAME: 12 05 07

W.I. 12 05 07

CLINICAL: 12 05 07

EXPLANATION: 12 05 07

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 2 5 4 1 7 | |
|--|--|--|--|---|---|---|--|---|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LOIS ELAINE HEBBLER ZIETHEN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10/12/82 | | 2b. HOUR 6:45P_M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 17, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH TOWSON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N CHARLES ST GBMC | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY Medicine | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Phoenix | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3811 Sweetair Road 21131 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Oscar L. Hebbler | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Erickson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 500-11-7557 | | 17. INFORMANT ADDRESS Phoenix, Md. Howard Ziethen, 3811 Sweetair Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC UNOPERABLE | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) OVARIAN CARCINOMA | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/20 , 19 82 , to 10/12 , 19 82 , that (I) (we) last saw the deceased alive on 10/12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR GENADRY | | | | | | 22c. ADDRESS 1134 York Road Suite 111 - Lutherville | | 22e. DATE SIGNED 10/12/82 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Balto. Md. | | | | | |
| 24. J. E. Lowell Lemmon, 10 W. Padonia Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 19 1982 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i> | | | |

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

[Faint handwritten text at the bottom of the page, possibly "Wiederholungs-..."]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 5 4 1 8 | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR HOUR | | | |
| EDWARD J. ZOLMAN | | | | 10 25 82 7:45P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | MONTH DAY YEAR 2 16 19 | | 63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | USA | | Baltimore City | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | |
| Towson | | Greater Baltimore Medical Center | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Electrician | | Beth. Steel | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Florida | | | | Del Ray Beach | | <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | | |
| John | | Justine | | 213-10-5135 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| yes | | WW 11 | | Bertha M. Zolman | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 5570 IMMEDIATE CAUSE (a) | | Extensive Bowel Infarction | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | (b) Superior Mesenteric Artery Thrombosis | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (c) Atherosclerosis | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 30, 1982, to Oct. 25, 1982, that (I) (we) lost saw the deceased alive on Oct. 25, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| Charles C. Brown | | | | | | Oct. 26, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Charles C. Brown, M.D. | | 6701 N. Charles St. Towson, MD 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 10-29-82 | | Gardens of Faith | | Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Lassahn Funeral Home | | 7401 Belair Rd. | | NOV 1 1982 | | John J. Connel | |



RECEIVED
JAN 11 1961
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 2 5 4 1 9 | | | |
|---|--|---|--|---|--|--|--|
| FOR 1. STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DOROTHY Mildred ZYNEL | | | | 2a. DATE OF DEATH MONTH DAY YEAR 10/16/82 | | | |
| 3 SEX FEMALE | | 4 RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR 9 24 27 | | 6 AGE (IN YEARS LAST BIRTHDAY) 55 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH TOWSON, MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Material Preparer | | 12b. KIND OF BUSINESS OR INDUSTRY Shoe | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Harford | | 13c. CITY Bel Air | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Byrd L. Thornhill | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Mae Leake | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 214-22-8741 | |
| 17. INFORMANT Vincent J. Zynel, Bel Air, Md. | | | | 17 ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1809 IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). CARDIO PULMONARY ARREST RESPIRATORY AND CARDIAC FAILURE METASTATIC CERVICAL CANCER | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: G I BLEEDING | | | | | | | |
| 19a. DATE OF OPERATION 10/08/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CERVICAL CA & METASTASIS | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (w) lost saw the deceased alive on 10/16/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (w) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] DEGREE | | | | 22c. DATE SIGNED Oct 16, 82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN K. YACOB M.D. | |
| 22e. ADDRESS GBMC | | | | 22f. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 19, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md. | |
| 24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 | | | | 25a. DATE REC'D. BY REGISTRAR OCT 18 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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RECEIVED
JAN 24 1955
SALT LAKE COUNTY

OWSON, EDWARD
1210 S. CHARLES ST.
SALT LAKE CITY, UTAH

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SALT LAKE COUNTY

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